University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 25 May 2022

13:15 – 15:15

For members of the Board: Boardroom, Poole Hospital

For members of the public: Via Microsoft Teams

(Link to join meeting can be found in Outlook Diary Appointment)

University Hospitals Dorset NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1

HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors held in public will commence at 13:15 on Wednesday 25 May 2022 via Microsoft Teams for members of the public and Boardroom in Poole Hospital for members of the Board.

If you are unable to attend, please notify the Company Secretary's Team, telephone **0300 019 8723**

Philip Green
Acting Chairman

Please note that mobile devices and laptops may be in use during the meeting to access papers, record actions and notes as appropriate

AGENDA – PUBLIC MEETING

13:15 on Wednesday 25 May 2022

Time	Item		Method	Purpose	Lead
13:15	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	2	Declarations of Interest	**Verbal**		**Chair**
	3	Patient Story	**Verbal**	**Noting**	**CNO**
	4	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 30 March 2022	**Paper**	**Approval**	**Chair**
	5	Matters Arising - Action List	**Paper**	**Review**	**Chair**
	6	Chief Executive Officer's Report	**Paper**	**Noting**	**CEO**
13:45	**7**	**QUALITY AND PERFORMANCE**			
	7.1	Update on Covid	**Verbal**	**Noting**	**CNO/ COO**
	7.2	Covid Inquiry	**Slides**	**Noting**	**CNO**
	7.3	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Noting**	**EDs**
	7.4	Mortality Report	**Paper**	**Noting**	**CMO**
	7.5	Ockenden Review	**Verbal**	**Noting**	**CNO**
	7.6	Reviewing Gender Pay	**Paper**	**Noting**	**CPO**

14:40	**8**	**GOVERNANCE**			
	8.1	Freedom to Speak Up Guardian Report	**Paper**	**Noting**	**FTSU**
	8.2	Register of compliance with Code of Governance	**Paper**	**Approval**	**CEO**
	8.3	Board Assurance Framework (Close/sign off previous years framework)	**Paper**	**Approval**	**CNO**
	8.4	Board Assurance Framework (Annual Framework)	**Verbal**	**Noting**	**CNO**
	8.5	Quality Impact Assessment Policy	**Paper**	**Approval**	**CNO**
	8.6	Annual SIRO Report	**Paper**	**Noting**	**CIO**
	8.7	Seal of Documents Register	**Paper**	**Noting**	**CoSec**
	8.8	Gifts and Hospitality Register	**Paper**	**Approval**	**CoSec**
	8.9	Register of Interests	**Paper**	**Approval**	**CoSec**
	8.10	Board Meeting Schedule	**Verbal**	**Noting**	**CoSec**
	8.11	Final Annual Operational Plan	**Paper**	**Approval**	**CSTO/ CFO**
	8.12	Annual Certificates: • Availability of Resources • Systems for Finance Compliance (condition G6)	**Paper**	**Noting**	**CFO**
	8.13	Annual Certificates: • Certification of Governance and AHSCs – The Corporate Governance Statement • Training of Governors (S151 Act)	**Paper**	**Noting**	**CEO** **Chair**
15:05	**9**	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 22 May 2022 to company.secretary-team@uhd.nhs.uk		**Receive**	**Chair**
	10	Any Other Business	**Verbal**		**Chair**
	11	**Date and Time of Next Board Meeting Held in Public:** Board of Directors Part 1 Meeting on Wednesday 27 July 2022 at 13:15 via Microsoft Teams Future Meeting Dates: 28 September 2022 and 30 November 2022			

	12	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
15:15	**13**	**Close**	**Verbal**		**Chair**

Items for Next Board Part 1 Agenda

- Quality Impact Assessment Overview Report
- Annual Infection Prevention and Control Report – Board Assurance Statement
- Guardian of Safe Hours Report
- Annual Complaints Report
- Annual CQC Report
- Quality Assurance for Responsible Officers and Revalidation
- Annual Health and Safety Report
- WRES
- Annual Quality Account
- Workforce Strategy Committee Annual Report
- Quality Committee Annual Report
- Finance and Performance Committee Annual Report
- Transformation Committee Annual Report
- Sustainability Committee Annual Report
- Audit Committee Annual Report
- Private Patient Strategy Committee Annual Report
- Charitable Funds Committee Annual Report
- 7 Day Services Board Assurance Framework
- Annual Security Report

University Hospitals Dorset
NHS Foundation Trust

AGENDA – PRIVATE MEETING – PART 2

15:30 on Wednesday 25 May 2022

Time	Item		Method	Purpose	Lead
15:30	**14**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	15	Declarations of Interest	**Verbal**		**Chair**
	16	For Accuracy and to Agree: Part 2 Minutes of meeting held on 30 March 2022	**Paper**	**Approval**	**Chair**
	17	For Accuracy and to Agree: Part 2 Minutes of meeting held on 27 April 2022	**Paper**	**Approval**	**Chair**
	18	Matters Arising – Action List	**Paper**	**Review**	**Chair**
15:40	**19**	**QUALITY, PERFORMANCE & RISK**			
	19.1	Risk Register Report	**Paper**	**Approval**	**CNO**
	19.2	Serious Incident Report	**Paper**	**Noting**	**CMO**
16:10	**20**	**STRATEGY AND TRANSFORMATION**			
	20.1	New Hospitals Programme	**Paper**	**Review**	**CSTO**
16:30	**21**	**GOVERNANCE**			
	21.1	Draft Annual Report and Accounts	**Paper**	**Noting**	**CEO**
16:55	**22**	Any Other Business	**Verbal**		**Chair**
	23	Reflections on the Board Meeting	**Verbal**		**Chair**
	24	**Date and Time of Next Private Board Meeting:** Board of Directors Part 2 Meeting on Wednesday 29 June 2022 via Microsoft Teams. Future Meetings: Wednesday 27 July 2022, 24 August 2022 and 28 September.			
17:00	**25**	**Close**	**Verbal**		**Chair**

* late paper

Items for Next Board Part 2 Agenda

- Estates Non-Compliance Action (under Matters Arising)

University Hospitals Dorset NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Board of Directors Part 1 meeting held on Wednesday 30 March 2022 at 13:15 via Microsoft Teams.

Present:	David Moss	Trust Chairman *(Chair)*
	Karen Allman	Chief People Officer
	Pankaj Davé	Non-Executive Director
	Philip Green	Non-Executive Director
	Debbie Fleming	Chief Executive
	Peter Gill	Chief Informatics Officer
	John Lelliott	Non-Executive Director
	Alyson O'Donnell	Chief Medical Officer
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy & Transformation Officer
	Cliff Shearman	Non-Executive Director
	Paula Shobbrook	Chief Nursing Officer, Deputy Chief Executive
	Caroline Tapster	Non-Executive Director
In attendance:	James Donald	Associate Director of Communications
	Yasmin Dossabhoy	Associate Director of Corporate Governance
	Melloney Hartley	Patient Experience & Emergency Department Resolutions Officer *(for item 3)*
	Judith May	Deputy Chief Operating Officer
	Laura Northeast	Interim Head of Patient Experience *(for item 3)*
	Lorraine Tonge	Head of Midwifery *(for item 7.5)*
	Sarah Locke	Deputy Company Secretary *(minutes)*

BoD 056/22	**Welcome, Introductions, Apologies & Quorum** The Chair welcomed everyone to the meeting. Apologies were received from: • Mark Mould, Chief Operating Officer *(represented by Judith May)* • Stephen Mount, Non-Executive Director. The meeting was declared quorate.
BoD 057/22	**Declarations of Interest** No further interests were declared.
BoD 058/22	**Patient Story** The Chief Nursing Officer introduced Laura Northeast and Melloney Hartley to present the patient story. The story focused on work within the Complaints Team, specifically relating to the benefits of individuals with nursing experience being in the team and with a focus on early resolution of complaints. Melloney is a registered nurse with 20 years' experience but since November has had the opportunity to work in the Patient Advice and Liaison Service (PALS) Team, in a post that has been funded from NSHE/I.

	The team shared examples of how important this role is by assisting patients and carers with their medical queries. Having a Nurse in PALS has had a positive impact for patients. Many complaints have been addressed at first contact with the PALS team and been resolved which has resulted in a sharp decline in formal complaints being received. A red flag process had been introduced into the PALS triage system to support clinical concerns being specifically addressed. There had been some additional funding secured to extend this role further. The Board thanked the team for their work and supporting staff and patients.
BoD 059/22	**For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 26 January 2022** The minutes of the meeting held on 26 January 2022 were APPROVED as an accurate record.
BoD 060/22	**Matters Arising – Action List** The Chair summarised the action list. **BoD178/21 –** The Quality Impact Assessment Policy will be brought to the meeting in May 2022. The action remained OPEN.
BoD 061/22	**Chief Executive Officer's Report** The Chief Executive presented the report, highlighting the following key points: • The Trust expressed its sympathies to staff with families and friends in Ukraine. Support and ways to provide practical help have been shared within the paper. • The Covid situation remains extremely challenging. The numbers of patients and staff with Covid has been steadily increasing which was having a significant impact on the Trust. • The challenges continue from having a large proportion of the bed capacity taken up by those patients that are medically ready to leave. • There was positive work with the Improving Flow Programme, which involves partners to assist with the challenges in the Trust. • Staff are extremely tired with a lot of staff on sick leave so there has been a focus on supporting teams during the current pressures. • There were very robust transitional arrangements in place for the Chairman and the Chief Executive with Paula Shobbrook as the Acting Chief Executive and Philip Green as the Acting Chairman in the interim from 1 April 2022. • The staff survey results had been embargoed until the 30 March 2022 but would be published imminently. Although the response rate was a little higher than last year, it was not as high as anticipated, but this does reflect the business of Trust. • The Chief Executive expressed her thanks to the Chaplain and the Communications Team who had arranged a remembrance service on each of the three sites in memory of the staff and patients that have were lost through Covid.

	A Non-Executive Director asked the Chief Executive her thoughts on the outcome on the NHS given the considerable challenges. The Chief Executive felt that this had been the most challenging year, especially as many will have never worked through a pandemic previously. Her view was that capacity in the community needed to remain open to allow a better patient flow. The Board NOTED the Chief Executive's report.
BoD 062/22	**Update on Covid and Winter Update** The Chief Nursing Officer presented an update on Covid and the winter period, highlighting the following key points: • The case rates for Covid continued to increase. The locality currently had higher rates than the national average. • The Trust must continue to ensure that good IPC (Infection Prevention Control) practices were maintained in hospital, despite the changes in the community. • Covid vaccinations have had a positive impact in Dorset, with considerably fewer patients in ICU. • The local guidance is being changed in line with national guidance. The Chief Medical Officer reminded the Board that the way of monitoring numbers of cases in the community was not as robust as it has been given national changes to reporting and therefore the data is not as meaningful. A Non-Executive Director asked how the Trust was managing the requirement for staff to lateral flow testing (LFT) twice a week if they were required to pay for them. The Chief Nursing Officer confirmed that funding for hospital staffing had been secured and more information on this would be shared once it had been confirmed. The Chairman paid tribute to the Infection Control Team for their work during very difficult circumstances. Following on from the above discussion, the Board NOTED the Covid and winter update.
BoD 063/22	**Integrated Quality, Performance, Workforce, Finance and Informatics Report** Executive Directors presented the Integrated Performance Report, highlighting the following key points: **Operations:** • Referral to Treatment: 3 of the 4 key indicators were consistently being achieved or improving. The area of challenge was around the 104-week waits and capacity. • Follow up backlog was decreasing, and the planned waiting list had stabilised. • There was an improved performance against the diagnostic standard. The challenge for this continued to be availability of staff. • ED performance continued to remain challenging and had been logged on the risk register; however, there are a number of workstreams to focus on the improvement of ED performance. • Ambulance waits remained a concern regionally and nationally. • The number of referrals into the 2-week wait cancer pathway continued to increase. • The Trust continued to remain above the national standard for the 62-day performance.

Quality:

- The quality IPR was discussed at the Quality Committee.
- The number of falls and pressure damage being reported was a concern, particularly when triangulated against other metrics.
- Outbreak meetings for Covid had been stepped down but with wards on both sites being affected, this oversight had been restarted.
- There had been a reduction in the FFT responses. Volunteers were being brought back as some Covid restrictions were lifted which should help to increase the number of FFTs completed.
- Early resolutions remained the focus on complaints and this was reflected in the number of open complaints.
- Mortality metrics looked stable and were better when compared to the same period of the previous year.
- A deep dive into mortality had been presented at a previous Board Development Session.
- Fractured neck of femurs was going to be put in as a quality metric for next year.
- The Trust was an early adopter of the medical examiner system and is now an early adopter of distributing this service in the community, working with primary care colleagues, and this was proceeding well.
- There had been three serious incidents reported that have also been discussed at the Quality Committee in detail. The VTE prophylaxis was being flagged as a theme, with some concentrated work being undertaken around that.

Workforce:

- Staff sickness levels remained high; although there was a reduction in the sickness levels in February this had since increased.
- There had been some positive work with international recruitment.
- 13 trainee nursing associates have passed their programme.
- The increase in temporary staffing was an issue and work was being done to reduce the demand for this.
- Statutory and mandatory compliance remains good, but appraisal rates are low.

Finance:

- The Trust would start the new year with a significant deficit.
- There was a surplus of approximately £200-300k but the total figure was awaited.
- There had been a considerable increase in agency expenditure, with this being a reflection of the increase in staff sickness rates.
- The revenue position was expected to be delivered.
- There continued to be a strong cash balance position.
- Better Payment Practice performance was currently around 90%.

Informatics:

- The core infrastructure uptime had been sustained which is crucial to keeping services running.
- There had been some significant difficulties with degradation due to the increased activity required on the firewalls.
- There was a heavy demand on the service desk. More than half of the demand on the IT helpdesk was being requested through the self-service desk.

	• 7500 staff had now been enrolled onto single sign on. • There had been good progress made on the freedom of information and cyber security generally. Following on from the above discussion, the Board NOTED the Integrated Performance Report.
BoD 064/22	**Quality Impact Assessment Process** The Chief Nursing Officer presented the Quality Impact Assessment (QIA) Process, highlighting the following key points: • A QIA policy has been developed which would come back to the Board for approval in May 2022. • The current process for assessing impacts on quality was for any exceptions to be reviewed at the Quality Committee and escalated to the Board where necessary. There were no escalations required for this meeting. The Board APPROVED the Quality Impact Assessment Process.
BoD 065/22	**Nursing Establishment Review** The Chief Nursing Officer presented the Nursing Establishment Review, highlighting the following key points: • This was a review that was a statutory requirement and had been reviewed at the Workforce Committee. • A high-level account was being presented to provide assurance to the Board with the processes that are in place. • The Trust was meeting statutory and CQC requirements. • There had been 20 registered nurse degree apprentices that had gone through their recruitment campaign. • The newly qualified nurses had now been through induction. • The Trust had been successful in meeting the recruitment target for international recruitment. • Safe staffing had been maintained and mitigated in areas. The Chair of the Workforce Committee added that medical recruitment had been encouraging as there had been an increase in the numbers of people applying for posts and favourable comment was made on the calibre of candidates. There had been an enormous amount of work put into wellbeing, provided to support and sustain teams. He expressed that he is proud of what the Trust is doing in relation to wellbeing, this being reflected in having staff returning to work at the Trust. The Board were ASSURED by the Nursing Establishment Review.
BoD 066/22	**Ockenden Review and Kirkup Recommendations** The Chief Nursing Officer presented the Ockenden Review and Kirkup Recommendations, highlighting the following key points: • The full Ockenden report was published on 30 March 2022. • The Board require assurance of the care and governance that is in place at the Trust. • External oversight has been commissioned which has been shared at the Quality Committee and the Board. • 87% of the actions being taken had been achieved, as detailed on page 62 of the meeting materials. • The Kirkup report related to the findings in Morecombe Bay in 2017.

	• On page 63 of the meeting materials the self-assessment against the recommendations of Kirkup had been outlined. • The action plan would be sent back to the LMS. • The outstanding system actions through the LMS and the maternity dashboard, although there was good progress being made on the dashboard with the new IT system that had been implemented. • The development of the maternal medical network was in progress with the University Hospital Southampton. • A new audit midwife had been appointed. • Improvements were being made to the maternity matters website. • There were 15 further additional actions from the fully published report, which would be monitored through the Quality Committee. A Non-Executive Director highlighted that it was important that the Board has a clear line of sight to maternity services and to be committed to improving the safety and outcomes. She commented that as the Maternity Safety Champion, meetings with the maternity staff enabled her to be able to raise concerns or issues. Systems and processes were in place that allow staff to be able to raise concerns and establish a safety culture. A Non-Executive Director asked whether the Kirkup non-compliant actions were all in progress. The Head of Midwifery explained that they were marked as in progress as they were completed but the evidence to support this had been pending. There had been a review of the actions and evidence could now be provided for completed actions. A Non-Executive Director highlighted that there are learning points to be shared broadly across the Trust. The Chief Nursing Officer added that there would be a meeting with the National Director of Midwifery Services. The Board NOTED the Ockenden Review and Kirkup Recommendations.

BoD 067/22	**Strengthening our Approach to Reducing Health Inequalities**
	
	The Chief Finance Officer presented the Strengthening our Approach to Reducing Health Inequalities, highlighting the following key points:
	• This had previously been discussed at the Board meeting on 25 January 2022 and at the Board Seminar on 23 February 2022.
	• Health Inequalities (HI) were the 'unfair and avoidable differences in health status across population and between different groups within society'.
	• The NHS Constitution sets out a particular duty 'to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population'.
	• Covid highlighted the need to prevent and manage ill-health in groups that experience health inequalities.
	• Many of the services at the Trust already reduce Health Inequalities by the virtue of their configuration, however specific action had been taken to ensure a greater impact.
	• The main five priorities for HI at the Trust were:
	  ○ Restoring NHS Services Inclusively,
	  ○ Mitigating against digital exclusion,
	  ○ Ensuring data sets are complete and timely,
	  ○ Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes,
	  ○ Strengthening leadership and accountability.

	• Through the ICS HI Group the Integrated Care Strategy for addressing HI in Dorset continued to develop. • An Internal HI Group was being established to ensure oversight and appropriately target and support work in this area. • Judith May had been appointed as the new Director of Operational Performance and Oversight and would be the operational lead for this work going forward. The Chair asked how the HI work was publicised throughout the organisation. The Chief Finance Officer replied that the internal focus had primarily been around developing the culture and the Equality Diversity and Inclusion work through developing the staff networks but acknowledged that more needs to be done on health inequalities through the HI Group, once established. The Board NOTED the Strengthening our Approach to Reducing Health Inequalities.
BoD 068/22	**Proposed Quality Improvement Programme** The Chief Strategy and Transformation Officer presented the proposed quality improvement programme, highlighting the following key points: • A number of the quality priorities were set by using LERNS (Learning Event Report Notifications) and risk. • There had been uptake with several staff members who were trained in quality improvement activities. • The paper outlined the priorities that were being continued from the previous year, the areas where the teams were working with the QI Team support and the new priorities. • The new priorities for next year were: o AKI/Dialysis capacity and management o Blood glucose management o Managing the deteriorating patient in ED o Improving communication of prescribing queries between Medical and Pharmacy team. • This had been through internal scrutiny and prioritisation and worked alongside the focus of improving the emergency patient flow through the hospital. The Board APPROVED the proposed quality improvement programme.
BoD 069/22	**Merger Benefits Realisation Update** The Chief Strategy and Transformation Officer presented the merger benefits realisation update, highlighting the following key points: • Page 84 of the meeting materials outlined the key actions to be done immediately following the merger. These remained on track with the exception of two: o Merger Related Savings and Training Space. The training space was being delivered as a result of moving staff to Yeomans Way which also brought some of the teams together that were working across sites. o Image Now for Mortality Reporting. This was being managed and monitored. • Surveys were completed last year with the leadership community and would be repeated this year as this had not been fully integrated into the Trust. • The single leadership structure to tier 3 had been a huge benefit for the executive team, particularly throughout the pandemic.

	• On page 87 of the meeting materials, the longer-term clinical ambition areas were detailed. These were also being tracked. The Chairman noted that the merger benefits was a long-term ambition, and that integration was important although achieving it in detail would take time. The Chief Medical Officer reminded the Board that a key part of the Liverpool CQC report was around teams working in silo. The Board NOTED the merger benefits realisation update.
BoD 070/22	**Car Parking Policy** The Chief Strategy and Transformation Officer presented the car parking policy, highlighting the following key points: • The policy had been scrutinised at the Board, Finance & Performance Committee and had been through other groups such as staff partnership forum. • On page 95 of the meeting materials, the objectives were outlined following the removal of free parking by the Government. • The two historic car parking policies had been merged whilst balancing the costs. • There were a range of other steps being taken to benefit staff for those that do not drive to work. • The wider issue with cost of living would continue to be debated with the Government. A Non-Executive Director highlighted the gap between the number of permits and the number of parking spaces and asked if any modelling had been done to understand the consequences of having too many permits. The Chief Strategy and Transformation Officer advised that there was a regular monitoring of car parking spaces. On peak days there were spaces available at the stadium in Poole and with staff working at Yeomans Way and home working, this had taken some pressure off the car park at the hospitals. The Board APPROVED the car parking policy.
BoD 071/22	**Independence of Non-Executive Directors** The Chairman presented the independence of Non-Executive Directors report, highlighting the following key points: • There are no circumstances found that has impeded the independence of Non-Executive Directors. • Following approval, references to this would be included in the annual report. The Board APPROVED the Independence of Non-Executive Directors.
BoD 072/22	**NHS Improvement's Terms of Licence – Draft Compliance Report** The Chief Executive presented the NHS Improvement's Terms of Licence – draft compliance report, highlighting the following key points: • This had been reviewed by Executive Directors and it was noted that the Trust is complying with the conditions. • There was nothing specific to bring to the Board's attention today. • This had been circulated to members of the Audit Committee, with one point of feedback in relation to G6.2 on page 162 of the meeting materials for a request for the Quality Committee to be amended to the Quality and Safety Committee.

	The Board APPROVED the NHS Improvement's Terms of Licence – draft compliance report with the amendment to the Quality and Safety Committee.
BoD 073/22	**Annual Board Effectiveness Report** The Associate Director of Corporate Governance informed the Board that the Annual Board Effectiveness Report, and the NHS Improvement's Terms of Licence – Code of Governance Report, would be brought back to the meeting in May 2022. **ACTION**: The annual board effectiveness report and the NHS Improvement's Terms of Licence – Code of Governance Report to be brought back to the May 2022 meeting. **Yasmin Dossabhoy**
BoD 074/22	**Annual Review of Effectiveness of Third-Party Processes and Relationships** The Chief Executive presented the Annual Review of Effectiveness of Third-Party Processes and Relationships, highlighting the following key points: • This report outlined the key partnerships for University Hospitals Dorset. • This may require further change in the future when more guidance around the ICS had been published. • Following approval at the Board, this would be published on the Trust website, in the interests of transparency. The Board APPROVED the Annual Review of Effectiveness of Third-Party Processes and Relationships.

BoD 075/22	**Questions from the Council of Governors and Public**
	The Board received questions from a Staff Governor:
	• Had there been a pattern analysis completed on falls and skin breakages?
	  ○ The Chief Nursing Officer confirmed that this is done and is part of the work of the falls team and part of the quality review.
	• Were there any ideas on having more staff surveys completed?
	  ○ The Chief People Officer replied that this was part of the follow up work that was being completed. Part of the action plan would be talking to staff and using feedback mechanisms to understand the pressures that prevented staff from responding.
	• Were there any plans for long Covid clinics via GP referrals?
	  ○ The Chief Medical Officer answered that there is a very successful long Covid clinic for staff. There was also a nationally and regionally organised long Covid clinic.
	• Were there any plans to partner with bus services?
	  ○ The Chief Strategy and Transformation Officer advised that this was being looked into, along with Bournemouth University who run services as well. This was also a topic for a future Informal Governor Briefing.
	The Board received a question from a public Governor in relation to the ED pressures and impact on ambulance waits, noting the concern around this for some time. The Governor enquired about the focus on this:
	  ○ The Chief Medical Officer responded that none of the staff felt that it was an acceptable situation. There was considerable work being done internally and there were external organisations also working with the Trust to improve the patient

	flow, such as ECIST who are specifically looking at how to improve flow through ED. There still needed to be input from partners in the system as there were still a very high number of patients with no criteria to reside that remained in hospital. ○ The Chief Finance Officer added that there was a significant investment into South West Ambulance Service from the Trust and other partners. The discharges from hospital needed to be addressed to create patient flow. The challenges with the ambulance services and the timeliness of responses to 999 calls was discussed at regional meetings. ○ The Chief Nursing Officer added that she and the Vice Chairman would be attending meetings with ICS colleagues to discuss this on a regular basis.
BoD 076/22	**Any Other Business** The Chairman announced that Sharon Collett has been elected as the Lead Governor and would be taking over this from David Triplow. She would formally start the role from 28 April 2022. The Vice Chairman wanted to thank Debbie Fleming and David Moss on behalf of the Board, Governors and the Trust. He said "there is almost 90 years of NHS service between them but more particularly we would like to thank you for the more recent years at University Hospitals Dorset, Royal Bournemouth and Christchurch Hospital and Poole Hospital. Bringing together two legacy Trusts together successfully, commencing a realignment of services, overseeing a major estates programme, the creation and development of a partnership with Bournemouth University, all against the background of a global pandemic. These are amazing achievements, and we are all proud of you both. It has been a pleasure for everyone to work with you and you will be missed very much. We wish you happiness and good health for the future." In response, the Chairman replied "We are very proud to have worked in these organisations. Nothing could be achieved without the total team of leadership at all levels. We are coming through some difficult times but there is a bright future for the organisation. Thank you so much for all your support on the journey." The Chief Executive added "It has been a real privilege, an honour and a pleasure to work with all of you and to serve with UHD ever since it was established. Working in the NHS is really the most fabulous opportunity. Thank you for all the support and encouragement. I've really enjoyed working with the Board at UHD because we all want to do the very best for our patients and local people.
	The date and time of the next Board of Directors Part 1 Meeting was announced as Wednesday 25 May 2022 at 13:15 via Microsoft Teams.

University Hospitals Dorset
NHS Foundation Trust

MATTERS ARISING: ACTION TRACKER PART 1 BOARD OF DIRECTORS MAY 2022

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Status
November 2021	BoD 178/21	**Quality Impact Assessment:** To present the updated Quality Impact Assessment policy to the January 2022 Board of Directors meeting.	PS	May 2022	Deferred from January to March 2022 meeting Complete. On 25 May agenda
March 2022	BoD 073/22	**Annual Board Effectiveness Report:** The annual board effectiveness report and the NHS Improvement's Terms of Licence – Code of Governance Report to be brought back to the May 2022 meeting.	YD	May 2022	Annual Board Effectiveness Report to be brought back following completion of Board Committee reviews. NHS Improvement's Terms of Licence – Code of Governance Report on agenda for May 2022.

Key:	Outstanding	In Progress	Complete	Future Action

University Hospitals Dorset
NHS Foundation Trust

Chief Executive Report
May 2022

1. Covid-19 update

The Trust continues to follow national guidance in order to manage our services safely as we move from a state of Covid pandemic, to living with the virus as an endemic. At the time of writing we had 67 Covid-positive patients, the majority of these patients in hospital with other conditions but also testing positive for Covid, as an incidental finding. I am pleased to report the reduction in the number of staff members off work with Covid, from 289 at the end of March 2022 to the current position of 81.

We continue careful oversight of the position, and the daily operational meetings to coordinate our response have now reduced to two meetings a week. Managing our response to Covid has been a phenomenal effort by so many staff across our hospitals – from clinical colleagues, operational teams, housekeepers, porters, infection prevention control teams, biomedical scientists, and logistics teams. I would like to thank all our teams who have led and contributed - recognising the resilience, commitment and compassion to patients and each other required during this sustained period of time.

2. Recovery

NHS trusts are under significant strain across the country and there remains unprecedented pressure on the urgency and emergency care pathways. The ongoing impact of Covid-19 and previously undiagnosed patients coming forward means growing pressure on tackling the backlog of care. Nationally, the NHS waiting list is 40% higher than it was two years ago. The NHS England and NHS Improvement delivery plan for tackling the Covid-19 backlog of elective care and restore activity to pre-pandemic levels, sets out four key ambitions:

- Delivering 30% more elective activity by 2024/25 than before the pandemic
- Eliminating waits of longer than 12 months for elective care by 2025
- 95% of patients to receive diagnostic tests within 6 weeks by March 2025
- 75% of urgent cancer referrals to be processed within 28 days by March 2024.

There are four areas of delivery: expanding capacity, prioritising diagnosis and treatment, reducing waiting times and providing better information and support for patients.

Our clinical and operational teams across UHD have been working hard over the last few months to address the current position and plan for the future. This includes validation of our waiting lists, using digital technology and speaking with patients, and

we thank all patients who have responded. We have also been developing 'My Planned Care', a resource to help patients find out more information about their condition and their waiting times, in order to enable informed choices about their own care. Details of this have been shared across our social media and it is available to access from our outpatients' section of our website.

I want to reassure patients waiting for elective procedures that we are doing as much as possible to ensure they are seen as soon as possible and are committed to tackling the backlog of our waiting lists and help every patient with their care.

3. Operational performance

As many will be aware, the Trust continues to operate under pressure, with a gap between the demand for emergency/urgent care and the capacity available within our organisation to meet this. Although the number of Covid-19 admissions is much lower than it was at the peak of the pandemic, this is still having impact on the work of the Trust.

The main challenges faced every day by staff working within UHD include the following:-

- Both sites continued to have all escalation & extremis beds open in April, however there is reduction in ringfenced infection control closed beds. However, despite this, occupancy remained high at 94.7%, and in some instances has exceeded 100% on a single site.
- The number of patients ready to leave with No Reason to Reside (NRTR) increased in month which means that around one-fifth of our capacity is not available for new admissions
- The lack of downstream beds results in delays in ambulance handovers and increased waiting times within our Emergency Departments although improvements were seen in both these areas during April.
- The current demand for emergency care beds and the reduction in accessible beds reduces the number of beds available within our hospitals for elective (planned) surgery
- Maintaining additional beds in response to demand requires more staff, at a time when there are already gaps in the workforce. This inevitably means that the Trust must increase its use of temporary/agency staff

In light of all the above, all our teams are extremely busy and staff are feeling the strain across all areas. The on-going emergency pressures make it hard to recover our elective (planned) work – as noted above - despite all our commitment and best efforts.

A number of key actions have been agreed that will make a difference in re-balancing capacity and demand, so that we are able to make better use of our collective resources. Three priority areas have been agreed, that will be taken forward:-

- Bi-weekly Rapid Decompression meetings are in place, chaired by the COO to target and oversee immediate actions to improve crowding in the Emergency Departments and flow through the sites. This is supported by the ongoing work with ECIST with pathways to Same Day Emergency Care, and the Trust Flow Improvement Programme which is now established and reporting to TMG.
- The development of the elective recovery programme to focus on opportunities to increase productivity, so as to maximise available resources, gain access to the national incentive schemes, and avoid financial penalties.
- review and take action to reduce agency spend across the various providers – including taking action to close unfunded beds.

4. Transforming our hospitals

Running parallel to continuing our care of patients and restoration of our elective work, our transformation programme has been picking up pace. This will see Poole Hospital become the major planned centre and Royal Bournemouth the major emergency centre in the next four years. We have reached some significant milestones this month including a ceremony on 20th May to mark the "topping out" of our new theatres block at Poole Hospital. I am grateful for all those who helped organise the event, as an opportunity to reflect what has been achieved to help benefit the people of our region with the creation of our new theatres.

The building work at Royal Bournemouth of the new BEACH building is also making progress, as well as the new pathology hub. We held a stakeholder engagement event this month to show partners this new hub and explain the benefits this will bring not just to our hospitals but also all our healthcare partners in Dorset. This innovative new facility will provide a wide range of pathology and research services and will include a specialist diagnostic hub which will be used to study and diagnose diseases and illnesses using the latest in medical technology to analyse anything from a simple blood test to advanced genetic screening. The diagnostic hub will be operational later this year with the build fully completed in the summer of 2023.

5. Staff celebrations

This month has also marked several important events for some of our clinical colleagues across UHD. On 5th May we celebrated the International Day of the Midwife, under the theme of '100 Years of Progress, 14th May was National ODP day, celebrating and sharing the work of the operating department practitioner profession, and from 10th May we celebrated International Nurses' week, focussed on the diversity of our nurses across our hospitals. We shared personal stories from nurses who have chosen to come to work at our hospitals from abroad, highlighting their values that

have led them to a career in nursing. UHD is very proud to welcome staff from across the world and we thank everyone who has joined us.

6. Royal visit

Another highlight of this month was the visit by His Royal Highness the Prince of Wales to Royal Bournemouth Hospital. He came to open our new Derwent 3 theatre which has been built in record time to help tackle our backlog of patients requiring orthopaedic operations. He also opened our new Lavender Garden, a very special space created in one of our courtyards on the east wing of the hospital. It was initially funded through our University Hospitals Dorset NHS Charity by theatres staff in memory of two colleagues who died of cancer in 2020, but since then other staff groups have become involved in memory of other colleagues who died during this time. I was very proud to introduce His Royal Highness to a range of colleagues from across our hospitals. He also did an impromptu walkabout next to the lake at RBH which proved very popular for a wide range of colleagues who were there.

7. The Health and Care Bill

The Health and Care Bill has been passed by government and has Royal assent, which means Integrated Care Systems will be established as statutory bodies from July 2022. NHS Dorset has been progressing with plans and is on track for this milestone. There have been several appointments to their chief roles with Dr Paul Johnson as Chief Medical Officer Designate, Rob Morgan as Chief Finance Officer Designate, Dawn Harvey Chief People Officer Designate, Stephen Slough Chief Digital Information Officer Designate and David Freeman Chief Commissioning Officer Designate. Further appointments will be made to the remaining chief roles following the earlier appointments of Jenni Douglas-Todd as Chair Designate and Patricia Miller OBE as Chief Executive Designate.

8. UHD Appointments

I am delighted to report on several significant appointments for UHD, since the last public Board meeting.

Firstly, the new Chair for UHD - Rob Whiteman, CBE - will start in the role on 1 July 2022. Rob has been Chief Executive of the Chartered Institute of Public Finance and Accountancy for the last eight years and has held many other executive and non-executive roles; including Chief Executive of the London Borough of Barking and Dagenham and Chief Executive of the UK Border Agency. Rob also has extensive experience of working with the NHS and local authorities, from his time as Chair of North East London Sustainability and Transformation Programme (STP) and as a non-

executive director and chair of audit at Whittington Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust.

Our governor elections have concluded, and I am also pleased to report that Sharon Collett is our Lead Governor. Thank you to Sharon and all the governors for the work and support they provide for our hospitals and local communities.

I look forward to working with Siobhan Harrington when she joins us as our new Chief Executive on 1 June. Philip Green will continue to be acting Chair until Rob joins us, to support the transition and induction for our new UHD leaders. It has been a privilege working alongside Philip as acting Chief Executive since taking over from Debbie Fleming, who retired from the NHS at the end of March, and I would like to thank him for his leadership and support at this time.

Paula Shobbrook
Acting Chief Executive

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 7.3

Subject:	University Hospitals Dorset (UHD) NHS Foundation Trust Integrated Performance Report (IPR) April 2022

Prepared by:	Executive Directors, Alex Lister, Sophie Jordan, Judith May, David Mills, Jo Sims, Andrew Goodwin
Presented by:	Mark Mould-Chief Operating Officer, Pete Papworth -Chief Finance Officer

Purpose of paper:	To inform the Finance and Performance Committee on the performance of the Trust during April 2022 and consider the content of recovery plans
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce, finance and operational performance. It is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. The operational planning guidance (outlining the priorities for the year ahead) are detailed below: **Systems are being asked to deliver on the following ten priorities in 22/23:** A. Investing in the workforce and strengthening a compassionate and inclusive culture B. Delivering the NHS COVID-19 vaccination programme C. Tackling the elective backlog D. Improving the responsiveness of urgent and emergency care and community care E. Improving timely access to primary care F. Improving mental health services and services for people with a learning disability and/or autistic people G. Developing approach to population health management, prevent ill-health, and address health inequalities H. Exploiting the potential of digital technologies I. Moving back to and beyond pre-pandemic levels of productivity J. Establishing ICBs and enabling collaborative system working

Key points for Board members:

Operational Performance

Urgent and Emergency Care

Emergency Care @ UHD

Emergency flow remains a key challenge. Attendances to our Emergency Departments are now at pre-pandemic levels.

Daily ED attendances and Ambulance conveyances are consistent with March. *Ambulance delays remain high but have shown improvement from March with 24% less waiting more than 60 minutes to handover patients.*

Hospital occupancy continues to create challenges. *The total number of patients in our Eds for more than 12 hours has however reduced in April but remains above the 2% standard (5.8%).*

Emergency Departments

The IPR provides the detailed performance against the new national Urgent & Emergency Care standards. Headlines include:

- Ambulance conveyances are stable with the average number daily consistent for March and April.
- ED mean time significantly improved at the *RBH site in month (reduction of 60 minutes compared to March.* PH saw a marginal deterioration driven by long bed waits. Non admitted mean time improved on both sites - for RBH was at 259 mins, and 229 mins at Poole.
- There were 188 x 12 hour waits from Decision to Admit (DTA), double that of March.

(colours based on change from last month)

		Apr-22		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	307	314	311
Time to Initial Assessment	15 mins	8	7	7
12 Hour ED Waits	0	438	320	758
Internal Care Standards				
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	116	159	139
Mean Clinically Ready To Proceed to Leave Dept	60 mins	316	167	238

Bi-weekly Rapid Decompression meetings are in place, chaired by the COO to target and oversee immediate actions to improve crowding in the Emergency Departments and flow through the sites. This is supported by the ongoing work with ECIST with pathways to Same Day Emergency Care, and the Trust Flow Improvement Programme which is now established and reporting to TMG. Additionally, all escalation SOPs are being refreshed and roles and responsibilities for actions to respond to ED Crowding are being tested.

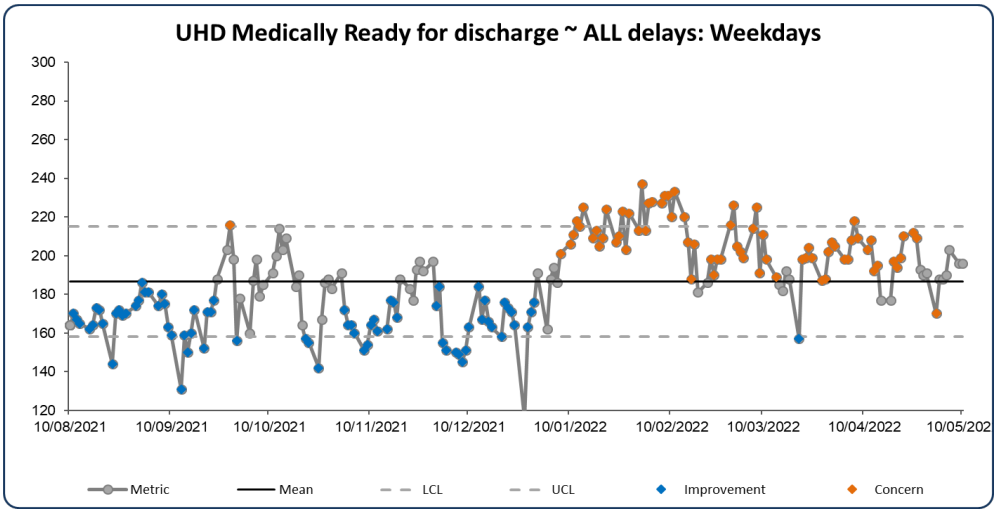
Occupancy, Flow and Discharge

Both sites continued to have all escalation & extremis beds open in April, however there is reduction in ringfenced infection control closed beds in use as patients are placed in specialty areas using robust risk assessment. *However, despite this, occupancy remained high at 94.7%, and in some instances has exceeded 100% on a single site.*

The number of patients ready to leave with No Reason to Reside (NRTR) increased in month to 202 (an increase of 4 patients per day). Occupied bed days remains high for patients with a longer length of stay (7/14/21+).

Challenges across the Dorset System continue to impact on discharging patients MRFD across UHD sites as follows:

- Transition into the new model for complex discharge now that national discharge funding has ceased, managing to maintain rate of complex discharges on pathways 1-3. Ambition that this will improve now that system is operating back to responsible commissioner pathways for social care, continuing healthcare and self-funders.
- Future model scoping sessions for P1 Intermediate Care Model have commenced w/c on 9/5. 45% of complex discharges should go out on P1 in line with national modelling.
- Covid patients and contacts awaiting end of isolation period has been escalated to Gold, and a revised risk assessment process will be signed off on 11/5. Anticipate BAU 16/5.
- Work stream 4 Transforming Our Discharge task and finish groups delivering in line with decompressing ED and ambition of Transforming Hospital Flow. Focus on increasing P0, 1 2 and 3 and improving weekend discharges.
- Choice policy and planning for discharge re-instated. Back to basics senior medical and nursing leadership visible on wards.



Surge, Escalation and Operational Planning

At the time of writing, UHD has 86 confirmed Covid inpatients, which is a significant improvement on the previous month (198 patients). Levels remain above the 5% national planning.

Referral to Treatment (RTT)

92% of all patients should wait no more than 18 weeks for treatment

2022/23 Planning Requirements	Mar 22	April 22	
Referral to treatment 18 week performance	60.44%	56.1%	Target 92%
104 weeks	280	238	Trajectory 266 by April 22
Hold or reduce >52+ weeks	2,655	2,798	2715 by April 22
Stabilise Waiting List size	56,038	61,278	+6,028 v April 2022

High level elective care recovery actions include:

- *Ongoing clinically led waiting list validation*
- *Further expansion and improved utilisation of additional internal or insourcing and outsourcing capacity*

- *Continuing to promote use of digital technology*
- *Increased use of Patient Initiated Follow Ups and Advice and Guidance*
- *Delivery of capital transformation through initiatives under the Targeted Investment Fund to support elective recovery.*
- *Two organisational-wide improvement programmes:*
    a. Theatre improvement programme: value and efficiency
    b. Outpatient Enabling Excellence and Transformation programme

DM01 (Diagnostics report)
1% of patients should wait more than 6 weeks for a diagnostic test

November	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	13,755	11,011	2,744	**19.9%**

The DM01 standard has achieved 80.1% of all patients being seen within 6 weeks of referral, 19.9% of diagnostic patients seen >6weeks.

DM01 performance has reduced (worsened) in April compared to March by 4%. Increased demand for diagnostics and workforce gaps are impacting on the Trust's recovery of diagnostics performance.

High level diagnostic recovery actions include:
- Continuation of additional temporary endoscopy capacity
- Working collaboratively across both sites to standardise and reduce waiting times for cardiology, ultrasound, MRI and CT
- Outsourcing Ultrasound to the Independent Sector
- Insourcing radiological reporting to provide additional capacity
- Additional mobile CT and Echo capacity brought online

Cancer Standards
The overall rate of two week wait referrals in March 2022 were at similar levels when compared to March 2021. Sites seeing the highest increases in referrals in March were Lung (+57%), Urology (+28%) and Upper GI (+21%).

	Measure	Target	Q1 21/22 - FINAL	Q2 21/22 - FINAL	Q3 21/22 - FINAL	Mar 22 - FINAL	Q4 21/22 - FINAL
UHD	Cancer Plan 62 Day Standard (Tumour)	85%	79.1%	76.9%	70.9%	71.3%	69.3%
	62 Day Screening Standard (Tumour)	90%	88.1%	81.0%	87.0%	82.8%	83.8%
	31 Day First Treatment (Tumour)	96%	97.1%	97.4%	96.8%	98.3%	97.3%
	Subsequent Treatment - Surgery	94%	91.2%	92.2%	93.9%	89.9%	89.8%
	Subsequent Treatment - Radiotherapy	94%	99.0%	97.8%	100.0%	100.0%	99.3%
	Subsequent Treatment - Anti Cancer Drugs	98%	98.8%	98.1%	100.0%	100.0%	100.0%
	Faster Diagnosis	75%	76.5%	75.4%	66.6%	73.3%	71.9%
	Over 104 days (treated in month)	N/A	30	28	36	13.5	44.5

The total number on the UHD PTL continues to be just below 3000 and ranks 25th when compared nationally. Of the 30 trusts with the largest PTL's nationally, UHD has the 3rd lowest % of backstop patients and the 2nd lowest within the Wessex Alliance.

28-day FDS performance continue to improve in March but fell short of the 75% threshold reporting 73.3% with 6 tumor sites achieving the standard. The Trust has consistently achieved the 31-day standard and is expected to be achieved in April. 2 out of the 3 subsequent treatment KPI's were achieved in March with surgery falling short of the standard, mainly due to urology RARP capacity.

The 62-day performance in March was below the 85% threshold (71.3%), however remains above the current national average of 70.2% with UHD ranking 66th out of 141 trusts (only 22 trusts out of 141 achieved the 85% threshold in March). Performance in April is currently at 71.1%.

Factors impacting on standard

Demand	• Referral numbers continue to put additional pressure on several services at all stages of the pathway
Clinical Processing Capacity	• Patient choice continues to impact across all specialties - especially causing delays at diagnostic stage in some pathways • Specific challenges in several pathways - due to capacity to manage the increased demand - especially colorectal and breast. • Delays in histopathology reporting turnaround times, mainly affecting patients on a pathway at Poole Hospital. • Workforce capacity to manage the large 2 week wait volume, specifically fast track booking teams

High level actions include:

- A joint piece of work is being concluded through a Cancer Improvement Programme with a focus on delivering sustainability plan across the six high volume cancer tumor sites.
- Additional capacity has been sourced to mitigate the backlog of 1st OPA for 2ww referrals (colorectal, breast, gynae and head and neck)
- Review of capacity and demand work to establish the additional capacity required to meet recurrent demand.

Health Inequalities

The Dorset Intelligence & Insight Service (DiiS) Health Inequalities dashboard enables analysis waiting times disaggregated by ethnicity and deprivation (Dorset Patients only).
Analysis of the waiting list by IMD identifies that 8.58% of the Trust's waiting list are patients living within the bottom 20% by Index of Multiple Deprivation (IMD). This increases to 9.6% when analysing patients waiting over 52 weeks and 9.9% of the waiting list over 78 weeks. Where ethnicity is recorded 12% of patients are within Black and minority ethnic populations. This percentage is unchanged when analysing patients who have waited greater than 52 weeks.

Finance

Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who are medically ready for discharge. Within the Trust; both Emergency departments continue to operate under extreme pressure and we continue to care for over 200 patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate at Operational Pressures Escalation Level (OPEL) 4 with bed occupancy frequently exceeding 100%.

Operating under this pressure requires a relentless focus from all teams to ensure patients receive safe care. Having to operate under this pressure for such a sustained period has obviated the Trusts ability to progress transformation and efficiency schemes at pace. This has limited the Trusts

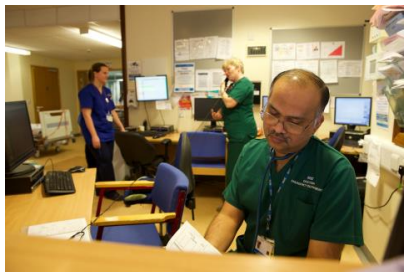
	ability to improve productivity and reduce expenditure and when compounded with the significant national workforce challenges and reduced COVID funding, makes it incredibly difficult to set a balanced budget. As a result, the Trust faces a very challenging year financially and has reluctantly set a deficit budget of £32.2 million. This deficit assumes full achievement of a very significant cost improvement programme of £27.4 million. At the end of the first month, the Trust has reported a deficit of £3.986 million against a planned deficit of £2.304 million representing an adverse variance of £1.683 million. This adverse variance reflects the current shortfall in the cost improvement plan which requires immediate correction. Additional actions have been implemented to recover the current shortfall and mitigate against further slippage. The Trust has set a full year capital budget of £122.1 million, including £94 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme enabling works. At the end of April the Trust has committed capital expenditure of£14.2 million against a plan of £16.9 million representing an underspend of £2.7 million. This underspend relates mainly to the New Hospitals Programme enabling works and the profile of spend against the new Pathology Hub. These programmes are expected to remain consistent with the full year budget albeit with some monthly variances throughout the year. The Trust ended April with a cash balance of £86.4 million, all of which remains fully committed against the medium-term capital programme. The cash funding of this capital programme is now at risk given the in-year revenue deficit, and funding solutions will need to be explored to mitigate this. The Trusts payment performance remained strong in April, with over 94% of invoices paid within the agreed terms.
Options and decisions required:	No decisions required
Recommendation:	**Members are asked to note and discuss:** • The aspects of the Trust's performance relating to finance and operational performance
Next steps:	Work will continue in addressing the actions raised as part of the escalation reports through the Trust Management Group.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	**To be a great place to work**, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best. **To ensure that all resources are used efficiently to establish financially and environmentally sustainable services** and deliver key operational standards and targets. **To continually improve the quality of care** so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience **To be a well governed and well managed organisation** that works effectively in partnership with others, is strongly connected to the local population and is valued by local people. **To transform and improve our services in line with the Dorset ICS Long Term Plan**, by separating emergency and planned care, and integrating our services with those in the community.
BAF/Corporate Risk Register: (if applicable)	**Risks scoring ≥12:** **UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak – increased score to 16 **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** - Demand for acute inpatient beds will exceed bed capacity (Demand & Capacity) **UHD 1460** – UEC national metrics **UHD 1429** – Ambulance handovers **UHD 1053 –**Long Length of Stay / Discharge to Assess /NRTR **UHD 1074** - Risks associated with breaches of 18-week Referral to Treatment and 52 weeks wait standards **UHD 1292** – Outpatient Follow-up appointment backlog. Insufficient capacity to book within due dates **UHD 1386** – Cancer waits increasing due to increased referrals. **UHD 1276** – Delayed patient care due to delays in surgery for #NOF patients **UHD1574 -** Lack of Breast screening staff impacting on waiting times **UHD 1397**- Provision of 24/7 Haematology/ Transfusion Laboratory Service **UHD 1342 -**The inability to provide the appropriate level of services for patients during the COVID-19 pandemic **UHD 1283 -** There is a risk that we cannot adequately staff radiotherapy radiographer roles due to vacancies and maternity leave. **UHD 1739 -** Financial Control Total 2022/23 **UHD 1740 -** ICS Financial Control Total 2022/23 **UHD 1595 -** Medium Term Finance Sustainability **UHD 1416 -** GIRFT and Model Hospital
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	Date
Trust Board (Full report)	May 2022
Quality Committee (Quality)	May 2022
Finance & Performance Committee (Operational / Finance Performance)	May 2022
Trust Management Group	May 2022

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT

April 2022

Created May 2022

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	ytd	ytd var	trend
SAFE																											
Quality	Presure Ulcers (Cat 3 & 4)			12	6	10	8	12	12	13	16	11	15	12	15	8	10	6	7	6	13	14	5	4	4	-7	
	Inpatient Falls (Moderate +)			5	2	3	5	4	4	5	2	4	6	2	7	1	3	6	1	1	7	8	3	3	3	-1	
	Medication Incidents (Moderate +)			1	2	5	4	9	2	4	4	1	0	1	1	1	6	2	8	2	3	2	2	3	3	2	
	Patient Safety Incidents (NRLS only)			1379	1341	1654	1581	1537	1492	1239	1006	1140	1145	1073	1159	1229	1036	1178	1127	967	1106	932	916	936	936	-204	
	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	3	0	
		MSSA		1	2	3	9	8	4	6	4	3	2	4	5	5	5	1	4	4	3	7	5	5	5	2	
		C Diff		7	6	1	3	1	2	9	3	4	8	8	8	5	8	6	6	4	2	8	3	3	3	-1	
		E. coli		3	12	5	8	2	11	3	3	4	4	9	8	10	7	8	7	9	7	2	4	4	4	0	
EFFECTIVE																											
Mortality	SMR	Latest Jan 21	(source Dr Foster)	97.92	93.17	105.66	103.50	88.04	125.62	103.90	92.89	83.31	91.41	85.38	103.11	108.12	100.45	96.01	90.35	86.03					86.03		
	Patient Deaths		YTD	207	185	265	244	249	469	299	217	165	185	170	232	223	202	222	238	247	270	203	241	227	227	62	
	Death Reviews		Number	105	85	124	111	127	207	152	103	94	117	102	124	133	115	137	111	123	95	32	40	42	42		
	Deaths within 36hrs of Admission			30	35	40	36	49	47	39	37	30	29	33	48	38	19	33	44	36	48	34	29	41	41	11	
	Deaths within readmission spell			15	13	15	22	25	36	18	16	12	14	10	26	22	17	13	12	12	21	15	22	13	13	1	
CARING																											
	Complaints Received			57	48	51	56	62	53	53	51	60	68	62	52	57	51	39	20	27	48	38	60	47	47	-13	
	Complaint Response in month			57	48	51	48	49	43	59	59	47	26	64	53	55	28	32	39	58	37	37	48	35	35	-12	
	Section 42's			0	2	0	0	0	0	1	0	0	0	22	0	0	14	0	0	13	0	0	13	0	0	0	
	Friends & Family Test			90%	91%	91%	91%	91%	91%	91%	93%	90%	89%	89%	86%	86%	87%	87%	89%	91%	90%	89%	88%	88%	89%	-2%	
WELL LED																											
Safety	Risks 12 and above on Register			36	38	39	31	32	27	31	34	35	40	43	44	47	44	49	44	44	42	41	39	41	41	6	
	Red Flags Raised*			31	47	51	43	73	129	51	28	41	45	56	80	117	105	160	209	161	180	148	130	159	159	118	
	*different criteria across RBCH & PHT																										
	Overall CHPPD			9.5	8.8	9.0	9.4	9.4	8.3	9.4	9.3	5.7	5.3	5.2	5.0	4.7	4.6	4.7	4.8	3.3	4.7	3.2	4.6	4.5	4.5	-1.1	
	Patient Safety Alerts Outstanding			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
People	Turnover			10.40%	10.70%	10.40%	10.20%	10.00%	9.80%	9.40%	9.20%	9.00%	9.20%	11.50%	12.20%	12.40%	12.10%	12.20%	12.60%	12.81%	12.10%	13.50%	14.00%	14.50%	14.5%	3.7%	
	Vacancy Rate *(only up to Oct 2020)*			1.0%	0.7%	1.3%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6.0%	6.0%	1.9%	
	Sickness Rate			4.2%	4.2%	4.2%	4.4%	4.5%	7.1%	4.9%	7.1%	4.7%	4.7%	4.8%	4.9%	5.0%	5.1%	5.2%	5.2%	5.3%	5.1%	5.2%	5.4%	5.6%	5.6%	0.8%	
	Appraisals	Values Based		41.6%	53.5%	57.3%	61.5%	63.9%	63.7%	63.1%	62.9%	4.6%	9.0%	16.7%	25.7%	35.7%	48.7%	54.5%	58.2%	58.4%	55.3%	59.1%	59.1%	5.1%	5.1%	0.5%	
		Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	61.6%	62.7%	56.8%	55.4%	52.5%	50.3%	61.0%	62.8%	54.4%	61.1%	63.1%	54.1%	44.1%	38.8%	56.6%	55.5%	55.5%	0.1%	
	Statutory and Mandatory Training			86.52%	86.96%	88.37%	85.90%	85.80%	87.20%	86.50%	86.40%	87.20%	87.90%	88.20%	88.10%	88.60%	87.70%	86.50%	85.80%	86.18%	85.72%	85.60%	84.79%	84.50%	84.5%	-2.5%	

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	ytd	ytd var	trend
RESPONSIVE																											
Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	25	17	29	36	10	17	12	11	7	12	13	19	22	22	18	24	12	4	3	3	-45	
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	187	75	70	67	72	98	122	65	51	82	45	53	57	64	77	56	56	-199	
	ENA Risk Assessment	Falls		62%	61%	61%	61%	58%	51%	59%	59%	65%	62%	62%	57%	55%	56%	55%	53%	53%	51%	58%	56%	55%	55%	-9.9%	
	**infection eNA assessment*	Infection*		74%	73%	70%	64%	73%	54%	62%	64%	70%	66%	66%	61%	58%	59%	58%	56%	58%	54%	61%	60%	58%	58%	-12.0%	
	went live at RBCH	MUST		64%	64%	63%	65%	61%	57%	63%	63%	69%	66%	65%	61%	59%	60%	59%	57%	58%	55%	62%	60%	58%	58%	-11.4%	
	during April 20	Waterlow		61%	61%	61%	61%	60%	52%	59%	60%	65%	62%	62%	57%	55%	56%	55%	53%	53%	51%	58%	57%	56%	56%	-9.1%	
RTT	18 week performance %		92%	49.0%	56.2%	60.4%	63.4%	64.8%	63.0%	59.3%	58.2%	59.6%	63.2%	65.7%	65.2%	65.4%	64.1%	64.0%	64.0%	61.6%	60.9%	60.4%	61.0%	56.1%			
	Waiting list size		44,508	41,172	43,123	44,320	44,349	44,117	44,615	45,524	47,133	47,984	48,773	49,099	48,687	49,906	51,491	52,787	52,383	52,972	53,168	54,602	56,038	61,278			
	Waiting List size variance compared to Sep 2021 (cf Mar 19 up to Mar 21, cf Jan 20 up to oct 21)		0%	-3%	1.3%	4.1%	4.1%	3.6%	4.8%	6.9%	10.7%	7.8%	9.6%	10.3%	9.4%	12.1%	15.7%	18.6%	1.7%	2.9%	3.3%	6.0%	8.8%	19.0%			
	No. patients waiting 26+ weeks			16,950	17,001	14,220	12,131	10,738	10,904	11,672	12,408	12,692	12,682	11,972	11,085	10,929	11,508	11,600	11,746	12,904	13,561	13,829	13,765	17,433			
	No. patients waiting 40+ weeks			6,395	6,921	7,197	7,799	8,031	7,258	7,006	6,727	6,474	6,151	5,962	5,872	5,971	5,922	5,559	5,413	5,374	5,391	5,764	5,650	7,370			
	No. patients waiting 52+ weeks		0	2,050	2,636	2,998	3,242	3,439	4,273	5,325	5,595	4,816	4,156	3,737	3,402	3,408	3,480	3,442	3,322	2,968	2,777	2,680	2,655	2,798			
	No. patients waiting 78+ weeks			0	70	92	149	291	542	726	979	1,176	1,268	1,180	1,318	1,635	1,740	1,416	1,329	952	870	864	758	759			
	No. patients waiting 104+ weeks			0	0	0	0	0	0	0	0	9	24	66	101	133	178	247	248	273	295	408	280	238			
	Average Wait weeks		8.5	20.8	20.6	19.5	18.3	18.6	18.3	18.3	20.1	19.5	19.5	20.1	20.1	20.1	20.1	17.8	17.8	19.5	18.5	20.1	19.5	19.5			
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%	69%	67%	73%	73%	74%	75%	72%	73%	74%	75%	72%	70%	71%	75%	71%				
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%	60%	62%	67%	59%	60%	61%	60%	64%	58%	65%	63%	61%	62%	64%	63%				
	NOFs (Within 36hrs of admission - NHFD)		85%	40%	10%	26%	29%	25%	42%	67%	63%	20%	29%	23%	30%	30%	39%	20%	42%	4%	9%	32%	24%				
Outpatients	**Referral Rates**																										
	GP Referral Rate year on year +/-	*(prev yr baseline)*	-0.5%										200.1%	127.3%	86.0%	66.7%	50.5%	42.0%	38.3%	34.3%	33.5%	32.4%	29.3%	-19.7%			
		(19/20 baseline)	-0.5%	-45.8%	-37.8%	-34.4%	-32.0%	-28.2%	-29.5%	-29.0%	-22.4%	-12.6%	-10.2%	-8.6%	-10.8%	-10.8%	-10.9%	-11.3%	-10.7%	-10.2%	-10.8%	-10.7%	-7.0%				
	Total Referrals Rate year on year +/-	*(prev yr baseline)*	-0.5%										169.1%	120.5%	87.2%	70.3%	53.5%	42.6%	37.1%	31.2%	27.1%	26.4%	24.0%	-24.3%			
		(19/20 baseline)	-0.5%	-45.3%	-37.1%	-32.2%	-28.7%	-24.5%	-22.8%	-22.2%	-17.2%	-8.9%	-8.0%	-3.9%	-6.2%	-6.0%	-5.6%	-5.8%	-5.0%	-4.6%	-5.0%	-4.8%	-1.4%				
	Outpatient metrics																										
	Overdue Follow up Appts			13,652	13,941	13,722	13,099	13,941	14,883	15,775	15,669	15,404	15,266	15,330	15,389	16,272	16,487	16,174	15,846	16,393	16,523	16,649	16,503	46,566			
	Follow-Up Ratio		1.91	1.46	1.44	1.44	1.48	1.44	1.63	1.54	1.44	1.40	1.36	1.37	1.40	1.47	1.48	1.43	1.44	1.49	1.53	1.45	1.47	1.49			
	% DNA Rate		5%	5.7%	6.6%	7.0%	6.6%	6.0%	5.5%	5.0%	5.0%	5.7%	5.8%	6.3%	6.6%	6.7%	6.9%	6.9%	6.8%	7.1%	7.1%	6.7%	6.4%	6.7%			
	Patient cancellation rate			9.2%	9.9%	10.3%	9.5%	10.4%	12.1%	8.8%	5.4%	8.3%	9.1%	10.5%	12.2%	11.7%	13.0%	12.4%	11.8%	14.0%	12.9%	12.9%	13.2%	12.7%			
	30% reduction in face to face attendances																										
	% telemedicine attendances		25%	52.9%	44.5%	42.0%	43.1%	39.4%	52.1%	52.8%	42.5%	37.3%	34.1%	31.3%	28.7%	28.5%	26.1%	26.6%	26.7%	27.8%	26.5%	25.7%	25.8%	24.0%			
DM 01	**Diagnostic Performance (DM01)**																										
	% of <6 week performance		1%	19.5%	16.9%	9.8%	1.4%	2.7%	6.4%	5.9%	2.9%	3.7%	2.6%	1.8%	3.3%	6.1%	5.5%	5.5%	7.8%	14.3%	18.3%	13.1%	15.9%	19.9%			
Cancer	2 week wait (RBH not being monitored)			99.3%	95.4%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
	62 day standard		85%	76.6%	76.1%	77.9%	80.3%	77.5%	78.5%	71.6%	83.2%	76.1%	76.9%	79.8%	78.8%	77.3%	74.6%	71.3%	71.4%	70.0%	71.6%	65.5%	71.3%	70.3%	*(April provisional)*		
	28 day faster diagnosis standard		75%	80.3%	72.9%	76.6%	86.7%	78.6%	72.5%	80.2%	83.6%	75.9%	77.6%	75.3%	78.2%	75.2%	72.8%	68.0%	66.4%	65.4%	60.4%	72.3%	73.3%	71.1%	*(April provisional)*		
Emergency Dept	Arrival time to initial assessment		15	5.7	5.7	5.1	5.0	6.0	6.0	5.0	6.0	9.0	9.0	13.0	14.0	10.0	7.0	5.0	4.0	4.0	4.0	6.0	7.0	7.0			
	Clinician seen <60 mins %			31.0%	36.2%	39.9%	43.7%	41.8%	50.5%	52.9%	45.2%	30.6%	27.0%	18.3%	16.1%	17.1%	19.8%	21.4%	24.5%	30.6%	31.6%	23.7%	21.6%	26.9%			
	PHT Mean time in ED		200	227	206	210	230	235	266	235	205	217	229	239	250	274	266	280	277	298	297	285	300	307			
	RBCH Mean Time in ED		200	211	217	226	219	259	258	222	206	223	228	250	280	297	278	294	297	304	294	321	374	314			
	Patients >12hrs from DTA to admission		0	0	0	0	7	8	3	1	0	0	0	0	0	0	5	16	21	34	73	60	89	188			
	Patients >6hrs in dept			1833	1454	1540	1488	2126	2052	698	1072	1674	2110	2735	3656	4349	3679	4258	3980	4071	3763	4089	4923	4204			
	ED attendance Growth (YTD)	*vs prev yr*										94.3%	17.0%	56.1%	45.8%	37.4%	33.2%	31.5%	31.5%	31.5%	30.2%	31.2%	30.5%	64.3%			
		vs 19/20		-26.0%	-23.2%	-15.7%	-21.2%	-21.8%	-22.6%	-31.4%	-21.1%	-3.0%	-15.0%	9.0%	0.9%	1.7%	2.3%	2.8%	2.5%	2.8%	0.7%	0.5%	2.9%	-3.0%			
SWAST SCAST	Ambulance handover growth (YTD)	*vs prev yr*										43.0%	35.7%	22.9%	14.6%	9.8%	6.1%	2.7%	1.0%	2.7%	-1.3%	-2.0%	-3.3%	43.0%			
		vs 19/20				-6.7%	-7.5%	-7.0%	-4.7%	-11.9%	-4.4%	7.8%	8.8%	8.9%	7.3%	1.7%	2.4%	-0.4%	-2.6%	-0.4%	-5.9%	-7.2%	-7.6%	7.8%			
	Ambulance handover 30-60mins breaches			313	228	249	213	261	296	126	190	227	264	341	411	330	290	213	262	281	362	349	280	315			
	Ambulance handover >60mins breaches			56	52	48	57	103	203	12	20	42	67	117	168	238	203	127	175	164	510	655	727	557			
Patient Flow	Emergency admissions growth (YTD)	*vs prev yr*										33.2%	17.0%	2.2%	26.7%	21.1%	17.0%	14.4%	13.1%	14.4%	11.5%	10.9%	9.5%	66.1%			
		vs 19/20		-11.9%	-10.5%	-12.1%	-15.4%	-16.4%	-13.1%	-19.3%	-13.4%	-16.2%	-15.0%	-15.1%	-1.4%	-2.2%	-2.9%	-4.1%	-5.5%	-4.1%	-8.0%	-8.6%	-7.2%	0.0%			
	Bed Occupancy		85%		85.9%	86.0%	85.4%	85.2%	87.4%	84.6%	82.3%	85.1%	90.5%	90.3%	89.7%	92.5%	90.3%	92.4%	92.4%	91.3%	94.9%	94.4%	93.7%	94.7%			
	Stranded patients:																										
	Length of stay 7 days				380	394	385	311	443	311	347	338	374	390	407	483	467	475	514	500	553	544	530	549			
	Length of stay 14 days				197	214	219	155	242	155	184	178	195	216	233	296	294	295	328	318	360	359	339	361			
	Length of stay 21 days		108		108	126	132	86	144	86	105	103	115	132	148	198	198	202	224	224	260	253	238	247			
	Non-elective admissions				6089	6279	5673	6034	5231	6034	6130	6355	6463	6366	6486	6119	5972	6291	5852	5621	5823	5301	5899	5485			
	> 1 day non-elective admissions				3796	3932	3554	3686	3521	3686	3737	3873	4025	3885	4108	3950	3756	4009	3727	3575	3817	3339	3747	3488			
	Same Day Emergency Care (SDEC)				2291	2346	2118	2344	1710	2344	2387	2481	2437	2478	2374	2166	2211	2275	2123	2044	2004	1961	2149	1994			
	Conversion rate (admitted from ED)		30%		34.40%	36.10%	38.30%	36.90%	42.30%	36.90%	37.00%	33.90%	32.50%	30.40%	29.90%	29.00%	28.30%	30.10%	29.90%	32.70%	31.40%	28.20%	28.70%	29.20%			

Quality - SAFE

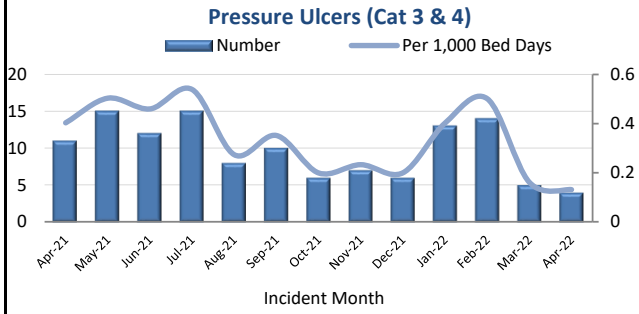
Commentary on high level board position

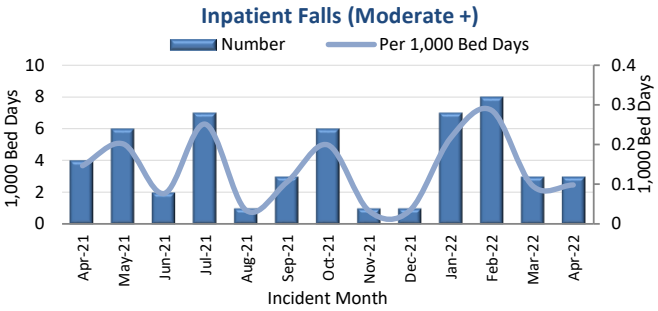
- A total of 4 cat 3's reported this month, educational focus on distinguishing between moisture associated skin damage and pressure ulceration.
- Three moderate fall incidents this month, two incidents were reporting fractures sustained following episodes of collapse, the remaining one was a result of a mechanical fall
- Two (2) new Serious Incidents reported in month (April 22). Full report on learning from completed scoping meeting and investigations included in CMO report to Quality Committee and Board.
- No Never events reported in month.

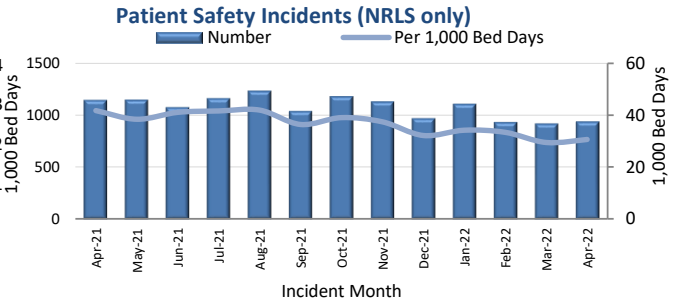
High level Board Performance Indicators

		22/23 YTD	21/22 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	4	11	-7
	Per 1,000 Bed Days	0.13	0.40	-0.27
Inpatient Falls (Moderate +)	Number	3	4	-1
	Per 1,000 Bed Days	0.10	0.15	-0.05
Medication Incidents (Moderate +)	Number	3	1	2
	Per 1,000 Bed Days	0.10	0.04	0.06
Patient Safety Incidents (NRLS only)	Number	936	1,140	-204
	Per 1,000 Bed Days	30.63	41.77	-11.15
Hospital Associated Infections	MRSA	0	0	0
	MSSA	5	3	2
	C Diff	3	4	-1
	E. coli	4	4	0

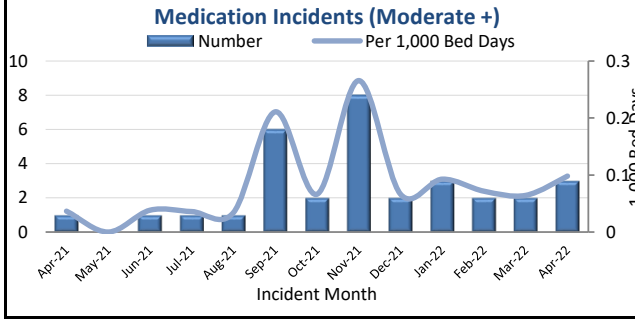
High Level Trust Performance

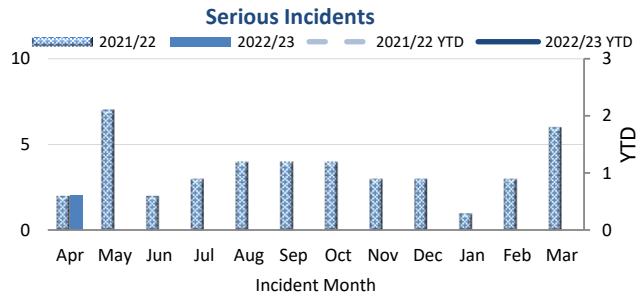


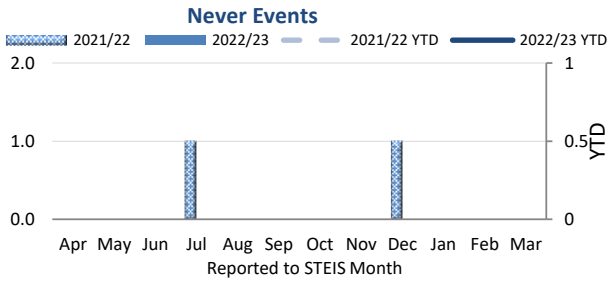




0 (Mar)	HAI: MRSA	0 (Apr)	5 (Mar)	HAI: MSSA	5 (Apr)	4 (Mar)	HAI: E. coli	4 (Apr)	3 (Mar)	HAI: C Diff (HOHA & COHA)	3 (Apr)







Quality - RESPONSIVE

Commentary on high level board position

- eNA compliance of the initial assessment completion within 6hrs of admission continues to be a challenge.

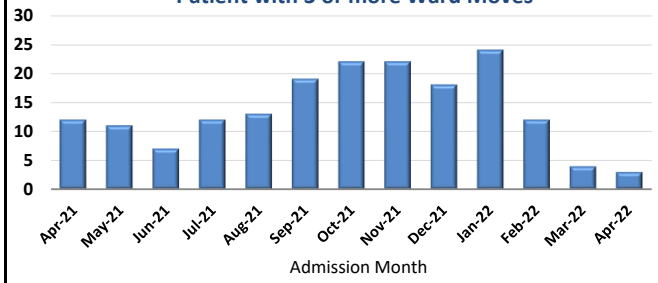
High level Board Performance Indicators

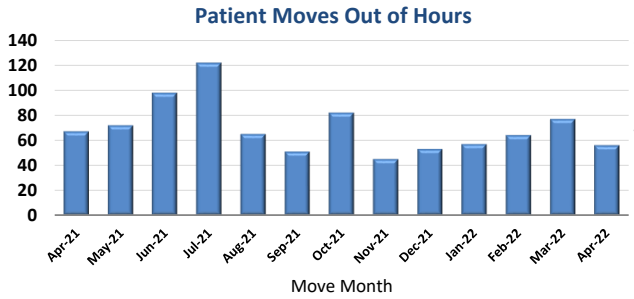
	22/23 YTD	21/22 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)	3	12	-9
Patient Moves Out of Hours (Non-Clinically Justified Only)	56	67	-11
Mixed Sex Acc. Breaches Suspended Apr20 - Sep21	0	0	0

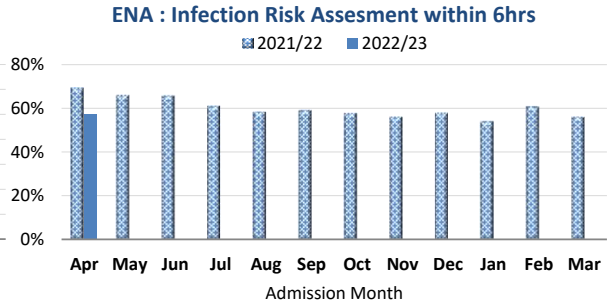
ENA Risk Assessment

Falls	54.7%	64.6%	-9.9%
Infection	57.5%	69.5%	-12.0%
MUST	58.0%	69.4%	-11.4%
Waterlow	55.6%	64.7%	-9.1%

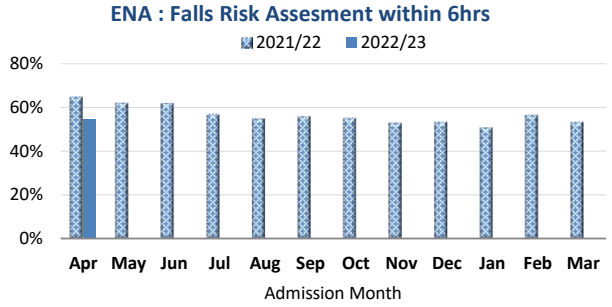
High Level Trust Performance

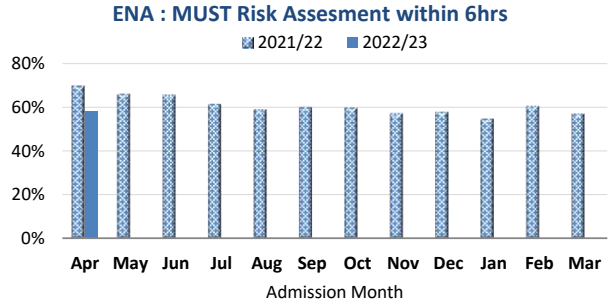


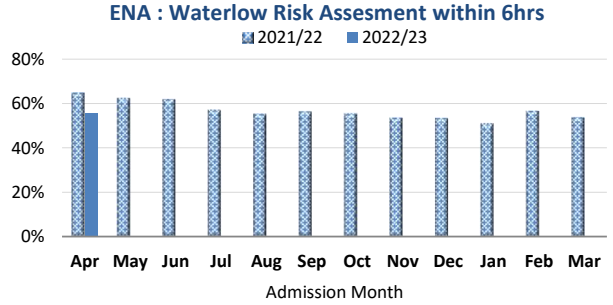




53.1% (Mar)	Falls	54.7% (Apr)	56.1% (Mar)	Infection	57.5% (Apr)	56.8% (Mar)	MUST	58.0% (Apr)	53.7% (Mar)	Waterlow	55.6% (Apr)







Quality - EFFECTIVE AND MORTALITY

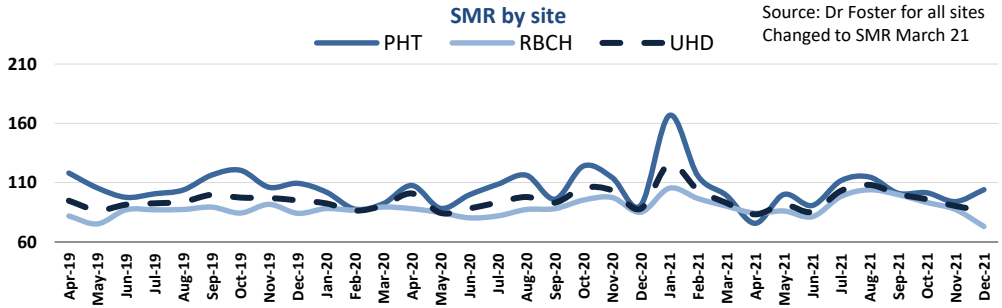
Commentary on high level board position

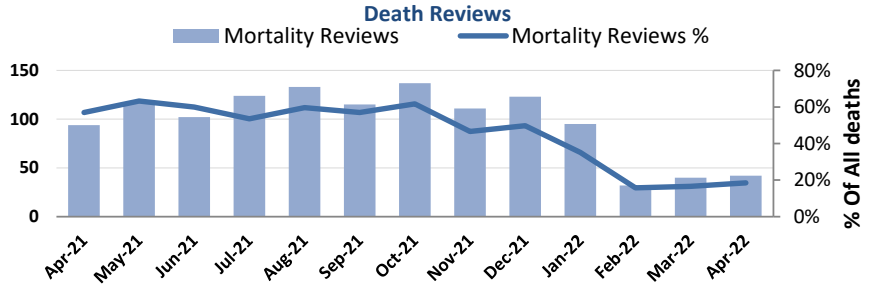
The Mortality Surveillance Group meets monthly (next meeting 12/5/22) and reviews mortality reports from speciality M&M meetings. The group also receives a quarterly report from the Lead Medical Examiner. Learning from mortality reviews and medical examiner screening during 21/22 has directly contributed to the Trust patient safety quality priorities for 22/23.

High level Board Performance Indicators

		22/23 YTD	21/22 YTD	Variance
SMR (Source: Dr Foster for all sites)	Latest (Dec-21 - UHD)	86.0	88.0	
Patient Deaths	YTD	227	165	**62**
Death Reviews Note: 3 month review turnaround target	Number	42	94	**N/A**
	Percentage	19%	57%	
Deaths within 36hrs of Admission		41	30	**11**
Deaths within readmission spell Patient readmitted within 5 days		13	12	**1**

High Level Trust Performance

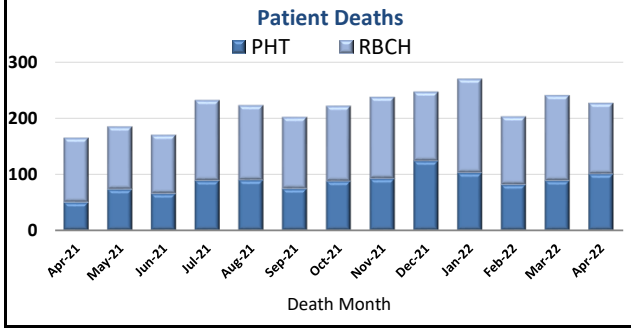


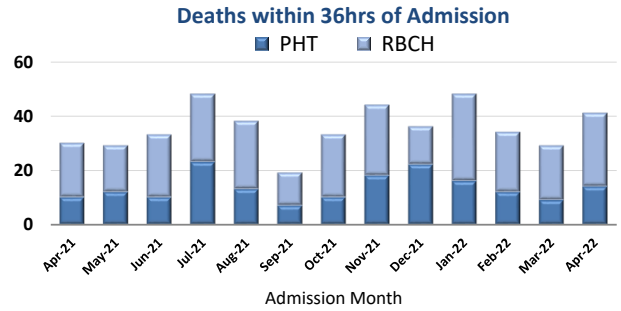


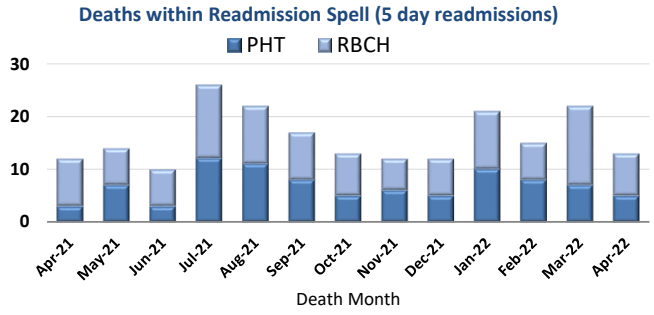
90.3 (Nov)	SMR	86.0 (Dec)

241 (Mar)	Patient Deaths	227 (Apr)

16.6% (Mar)	Deaths Reviewed	18.5% (Apr)







Quality - CARING

Commentary on high level board position

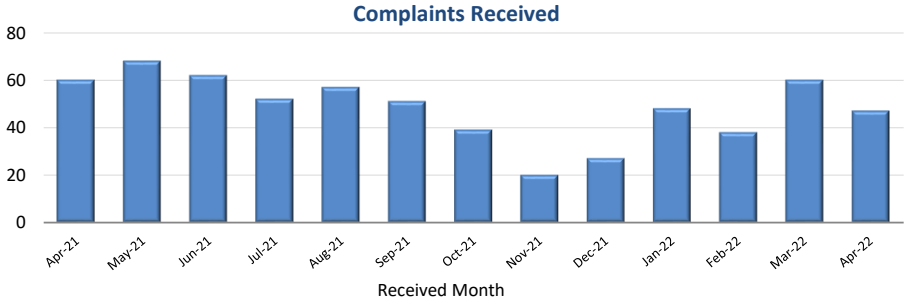
- FFT Positive responses remain the same this month at 88.2% compared with 88.3% in March. Results have seen a downward trend for three consecutive months and now a plateau (our lowest positive response this year was recorded in August at 86.36%)
- In April there were 26 new formal complaints and 25 Early Resolution of complaints processed. There are 107 outstanding open complaints, 41 of which have been open longer than 55 working days.
- The number of complaints closed in the month has further increased to 35, regular meetings with the care groups continue to focus on closing of complaints. Workforce pressures in the corporate complaints team are still expected to continue into another month due to vacancies. To give a more realistic time frame and to avoid extension of complaint responses, this has been communicated to complainants as 55 days, with an internal target to be less.

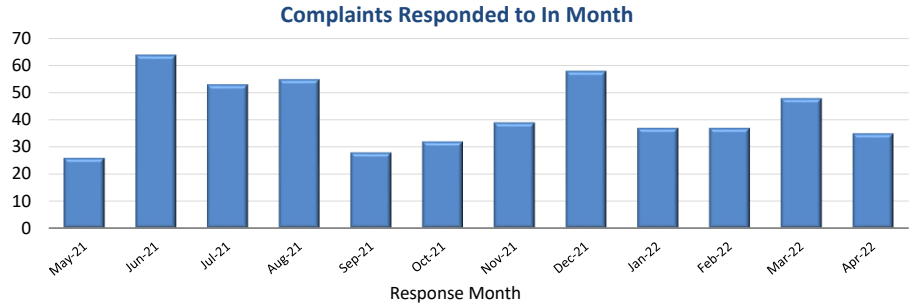
- **Key themes from PALS and complaints** :
- Clinical standards including outcomes and side effects
- Respect, Caring and Patient rights including caring and compassion and also disrespect
- Organisation process including delay – access (outpatient)

High level Board Performance Indicators

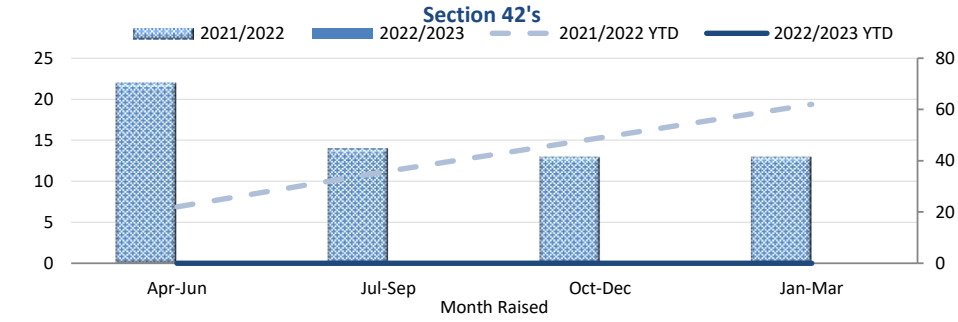
	22/23 YTD	21/22 YTD	Variance
Complaints Received	47	60	-13
Complaint Response Compliance	TBC		
Complaint Response in month	35	47	-12
Section 42's	-	-	-
Reported quarterly			
Friends & Family Test	88%	90%	-2%
New guidelines from June 2020			

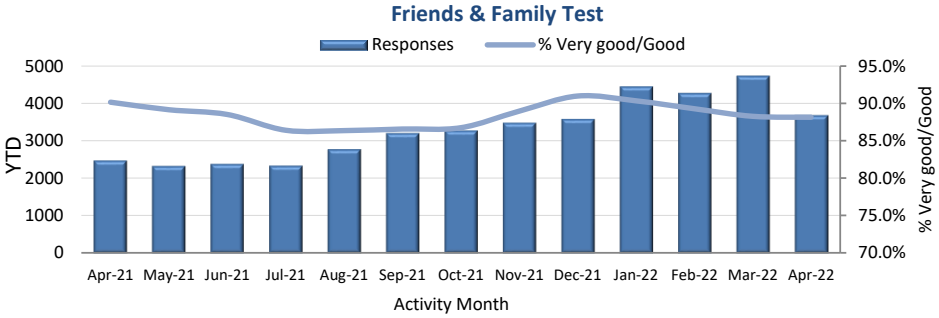
High Level Trust Performance





48 (Mar)	Complaints Received	35 (Apr)	60 (Mar)	Complaint Responses	47 (Apr)	88.3% (Mar)	FFT % V.Good/Good	88.2% (Apr)





Quality - WELL LED

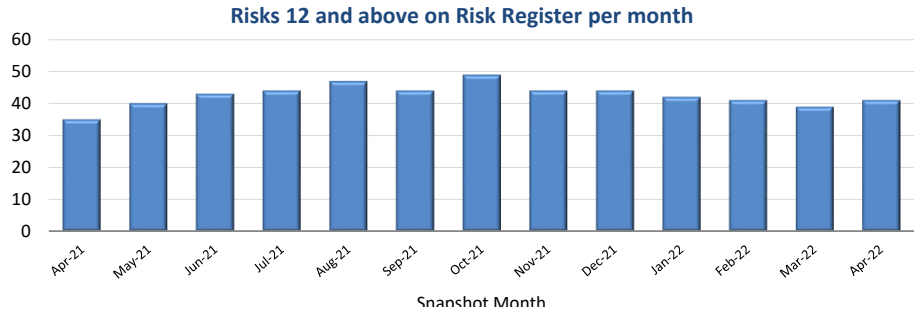
Commentary on high level board position

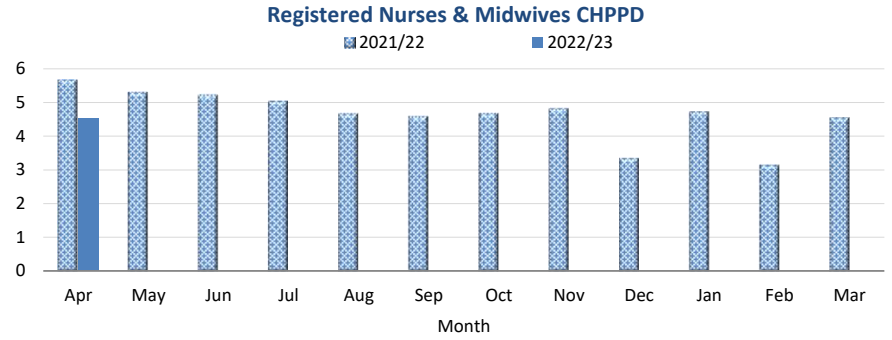
- Risk register update (as at 10/5/2022) provided in Quality Committee, TMB, and Board report
- Heat map risk reports provided to Finance and Performance Committee, Workforce Committee and Operations and Performance Group .
- Board Assurance Framework (BAF) 22/23 currently being developed following approval of Board objectives for 22/23 at April Board of Directors meeting.

High level Board Performance Indicators

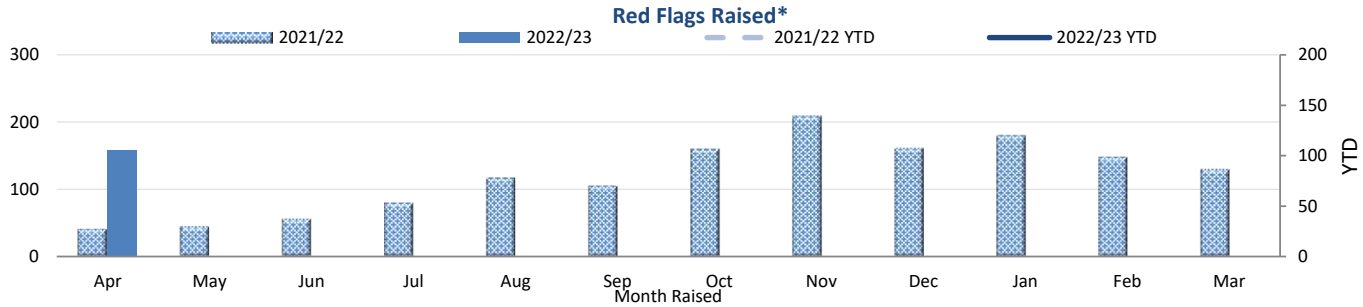
	22/23 YTD	21/22 YTD	Variance
Risks 12 and above on Register	41	35	6
Red Flags Raised*	159	41	118
*Source: SafeCare from Dec21. Criteria aligned.			
Registered Nurses & Midwives CHPPD	4.5	5.7	-1.1
Patient Safety Alerts Outstanding	0	0	0

High Level Trust Performance





39 (Mar)	Risks 12+	41 (Apr)	4.6 (Mar)	RN & RM CHPPD	4.5 (Apr)	130 (Mar)	Red Flags Raised	159 (Apr)



Workforce

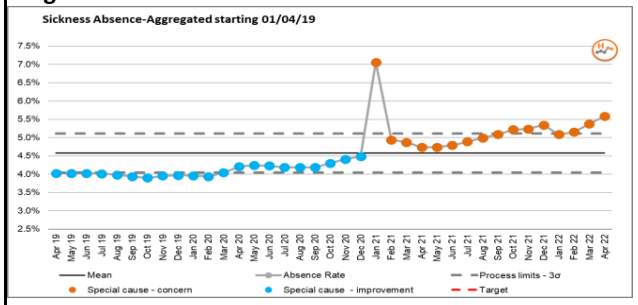
Commentary on high level board position

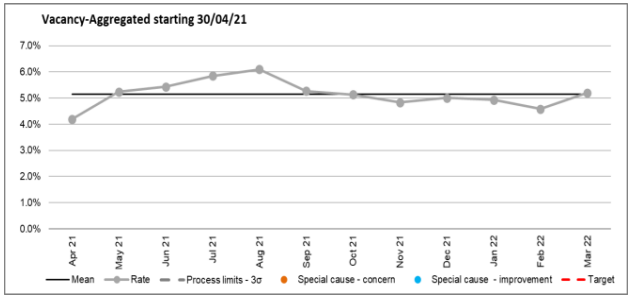
UHD turnover has risen to 14.5% actual this month, an increase of 0.5% from last month.
Vacancy Rate is showing at 6.4% actual this month, an increase of 0.9% on last month. Work continues to refine our establishment processing.
Overall Sickness absence Sickness absence for this month is 5.6%, a increase of 0.2% on last month. Staff absence due to Covid also increased from 0.33% to 1.03%.
Medical & Dental appraisal levels are reported at 55.5%. This does not correlate to information held in the trust's revalidation system. Work is underway to reconcile this system and ESR to increase reported compliance.
Value based appraisal levels are being reported at 5.1% for April. This is the first month of the new appraisal cycle for 2022/23.
Statutory and Mandatory training: Compliance continues strong, despite disruption caused by operational pressures during the preceding months. In April we saw a no change to March at 84.8%.
Note: For April YTD figures = Actual month figures.

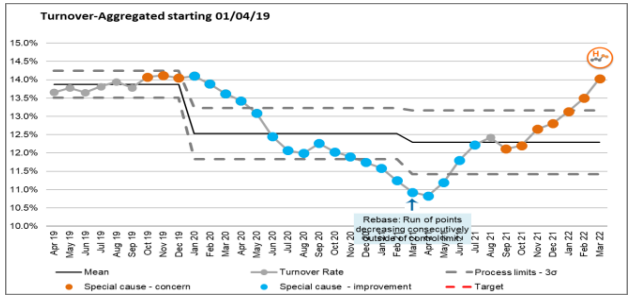
High level Board Performance Indicators

		22/23 YTD	21/22 YTD	Variance
Turnover (12 month rolling)		14.5%	10.8%	3.7%
Vacancy		6.0%	4.2%	1.9%
Sickness Rate (12 month rolling)		5.6%	4.7%	0.8%
Appraisals	Values Based	5.1%	4.6%	0.5%
	Medical & Dental	55.5%	55.4%	0.1%
Statutory and Mandatory Training		84.8%	87.2%	-2.5%

High Level Trust Performance





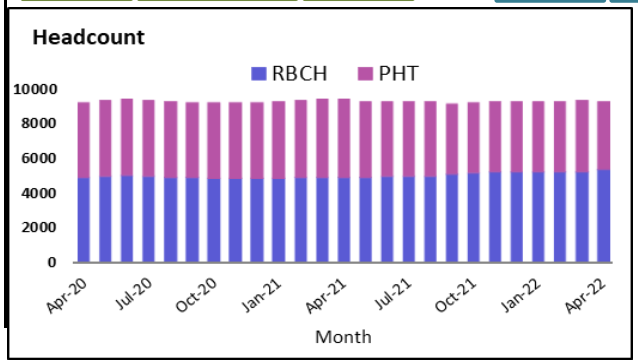


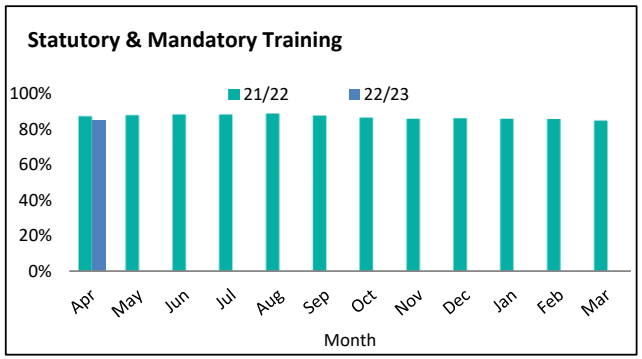
55.5% (Apr) | Appraisals (Medical) | 56.6% (Mar)

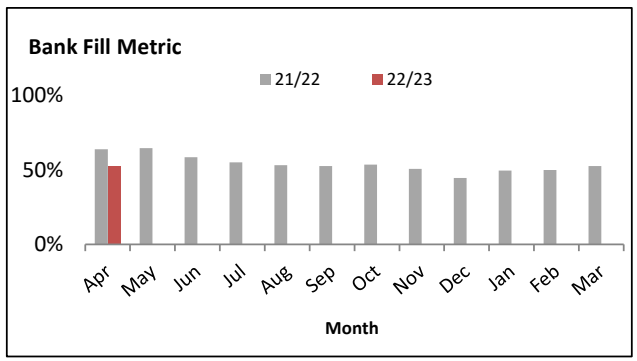
5.1% (Apr) | Appraisals (Values) | 59.1% (Mar)

14.5% (Apr) | Turnover | 14.0% (Mar)

5.6% (Apr) | Sickness Absence | 5.4% (Mar)







Emergency

Commentary on high level board position

Urgent Care remains extremely pressured. At both sites our Emergency Departments continue to experience unprecedented levels of crowding resulting in long waits and ambulance delays. Attendances have settled back to pre pandemic levels, with daily attendance in April an average of 434 patients. The non-admitted mean time improved at both sites in month (RBH reduced by 40 minutes, PH 5 minutes). RBH also saw improvement in admitted times (20 minutes), whereas PH saw deterioration by 50 minutes. This resulted in an overall improvement in mean time at RBH of over an hour compared to March, but a marginal deterioration in the Poole mean time of 7 minutes. As a Trust aggregate the average mean time improved by 14 minutes, whilst remaining significantly higher than the 200 minute standard.
UHD saw 14% decrease in patients spending more than 12 hours in the emergency department, however those waiting for a bed for more than 12 hours after decision to admit was double that in the previous month.

Ambulance delays continue to challenge the entire system. April saw a 24% reduction in Ambulances waiting over an hour at UHD when compared to last month. Decompressing the Emergency Department and a reduction in Ambulance Handover delays remains the key focus of the transformation and recovery actions in the Urgent and Emergency Care recovery and planning groups.

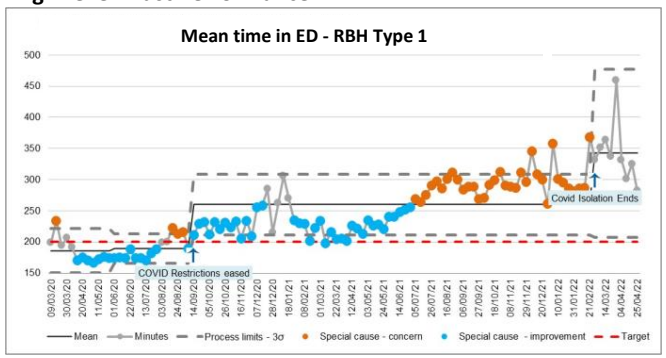
High level Board Performance Indicators

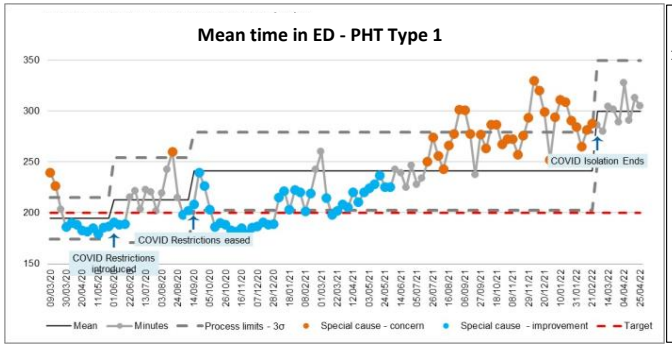
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	7
Clinician seen <60 mins		26.9%
PHT Mean time in ED	200	307
RBCH Mean Time in ED	200	314
Patients >12hrs from DTA to admission	0	188
Patients > 12hrs in dept		758
YTD ED attendance Growth vs 20/21 (vs 19/20)		94.3% (-3.0%)
Ambulance Handover		
YTD Ambulance handover Growth vs 20/21 (vs 19/20)		43.0% (7.8%)
Ambulance handover 30-60mins breaches		315
Ambulance handover >60mins breaches		557
Emergency Admissions		
YTD Emergency admissions growth vs 20/21 (vs 19/20)		66.1% (0.0%)

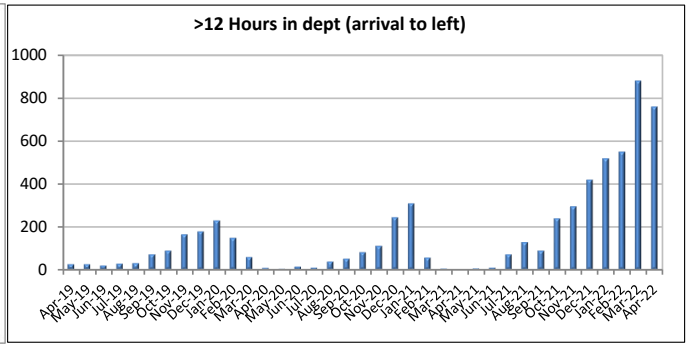
7 mins Mar-22 → Mean time to initial assessment → 7 mins Apr-22

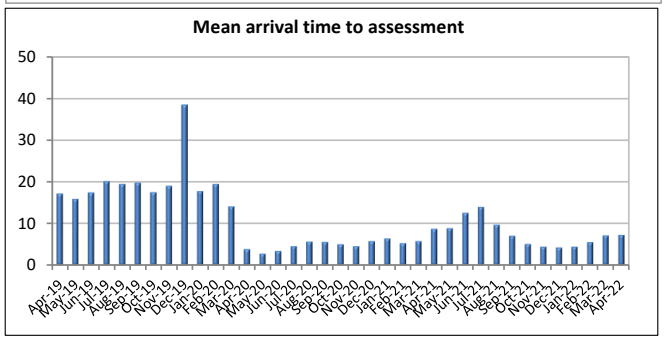
325 mins Mar-22 → Mean time in Dept. RBH & PHT → 311 mins Apr-22

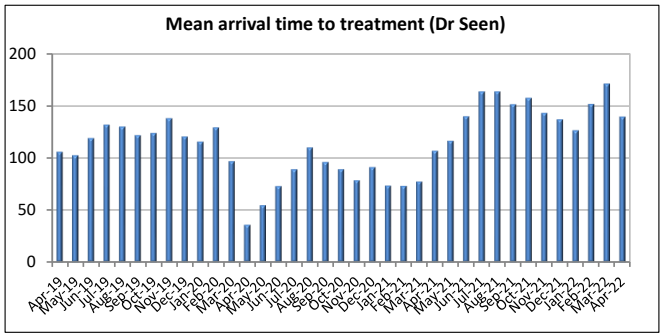
High Level Trust Performance

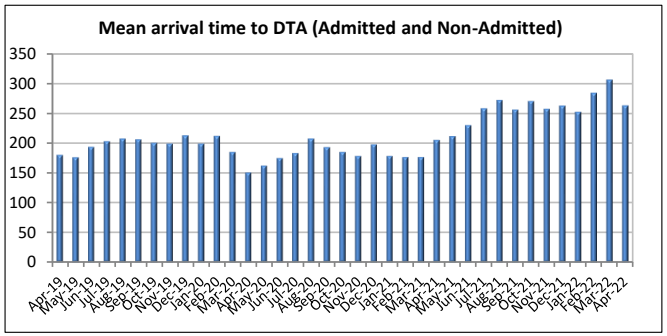












Patient Flow

Commentary on high level board position

Patient Flow

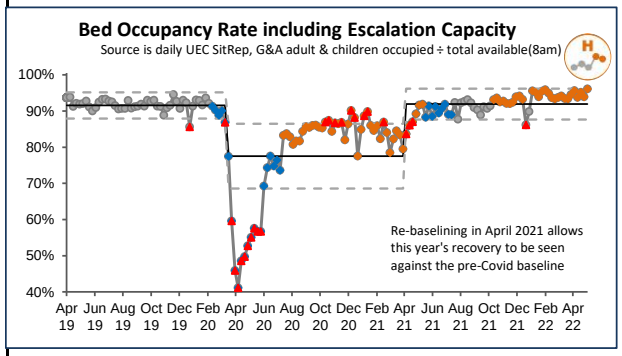
Bed occupancy has marginally increased in April to 94.7% (+1%) compared to the previous month. The high occupancy rate which is above the 85% national standard is attributed to the significant number of MRFD patients residing in acute beds and the impact of covid outbreaks. This has had a negative impact on the number of outliers across specialties. The figure also includes escalation/extremis beds which have been opened to support the pressures of designated covid bed capacity, maintaining elective activity and emergency care demand.

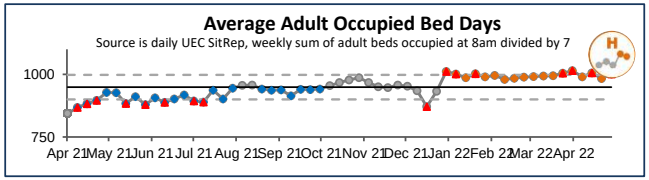
The ED conversion rate has increased slightly to 29.2% (+0.5%) and remains above the national standard. Monthly occupied beds day charts are averaged to compensate for each month having a different number of days. The adult volume is slightly up on previous months with more patients being discharged than admitted in the month, resulting in a net discharge of 60 patients.The mean bed wait for patients is 224 mins, which is higher than the previous month, impacting on flow out of the Emergency Department and ambulance handovers.

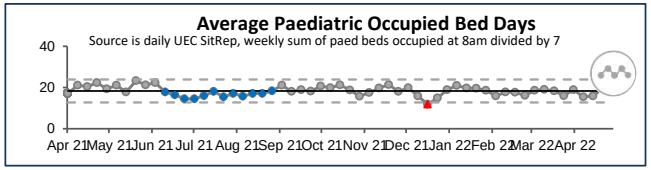
High level Board Performance Indicators & Benchmarking

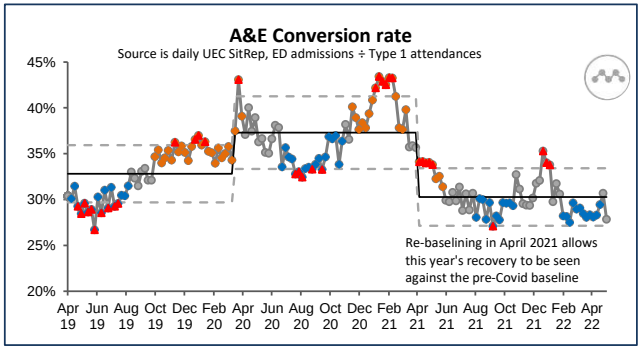
April 2022	Standard	Merged Trust
Patient Flow		
Bed Occupancy		
(incl. escalation in capacity)	85%	94.7%
(excl. escalation in capacity)		97.5%
Occupied Bed Days		30,534
Daily average Occupied Bed Days		*1017.8*
Admissions v Discharges		6,296 v 6,356
Net admissions	<= 0	-60
Non-elective admissions		5,485
> 1 day non-elective admissions		3,488
Same Day Emergency Care (SDEC)		1,994
Conversion rate (admitted from ED)	30%	29.2%
Mean bed wait: minutes *w/c 2 May*		224.02

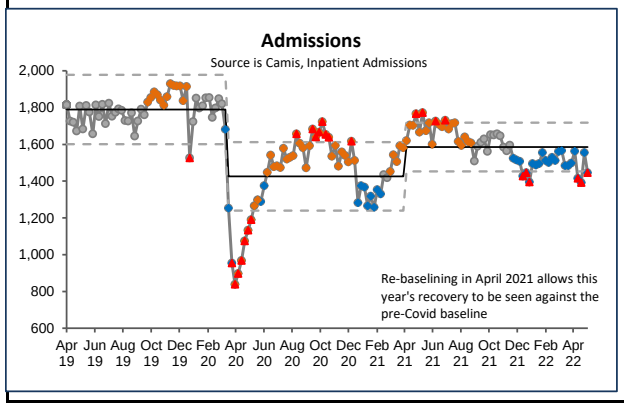
High Level Trust Performance (weekly)

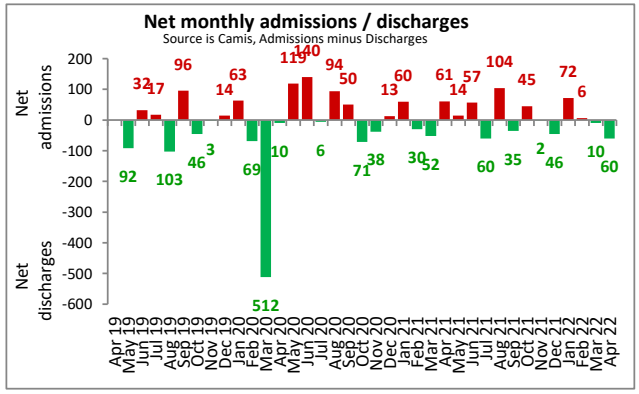


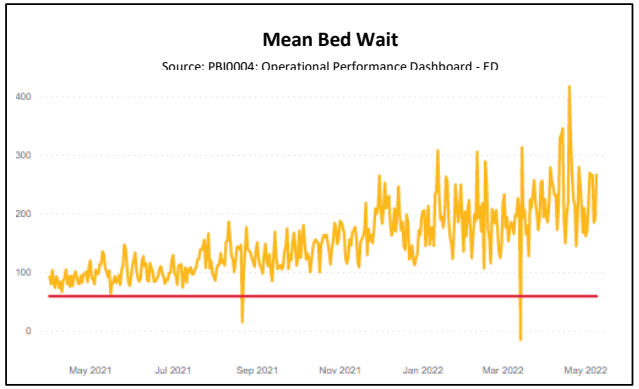












Length of Stay and Discharges

Commentary on high level board position

Patient Flow

The average number of beds per day occupied by patients with a length of stay>7 days has increased in month by 19 patients. The number of patients with a length of stay over 21 days has also increased to 247 (+9 patients). This is not a significant change in performance, continuing the generally high numbers so far in 2022, and remains above pre pandemic levels. The increased stay for stranded patients continues to have a detrimental impact on the national UEC metrics, particularly 12 hr DTA and ambulance handovers.

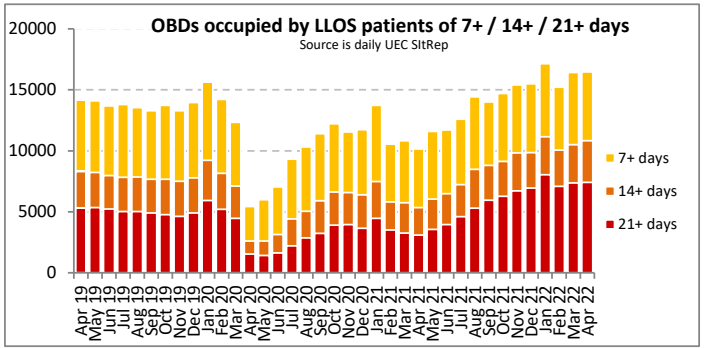
The average number of patients who are ready to leave/have no reason to reside (MRTL/NRTL) has increasd in month to 202 patients compared to 198 in March. The overall delayed discharge position continues to challenge hospital flow due to impact of covid suspensions on care homes/block booked beds and high staff sickness levels. The overall proportion of NRTR patients increased by 2%. Internal processes accounted for 18% of patients no longer meeting Criteria to Reside (C2R)

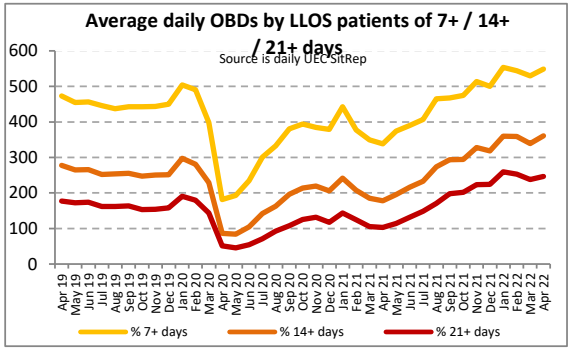
High level Board Performance Indicators & Benchmarking

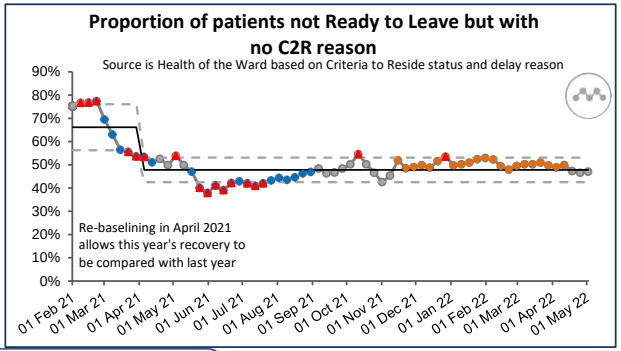
April 2022	Standard		Merged Trust	
Length of Stay and Discharges				
Stranded patients:				
Length of stay 7 days		*42%*	549	*53.9%*
Length of stay 14 days		*21%*	361	*35.5%*
Length of stay 21 days	108	*12%*	247	*24.3%*

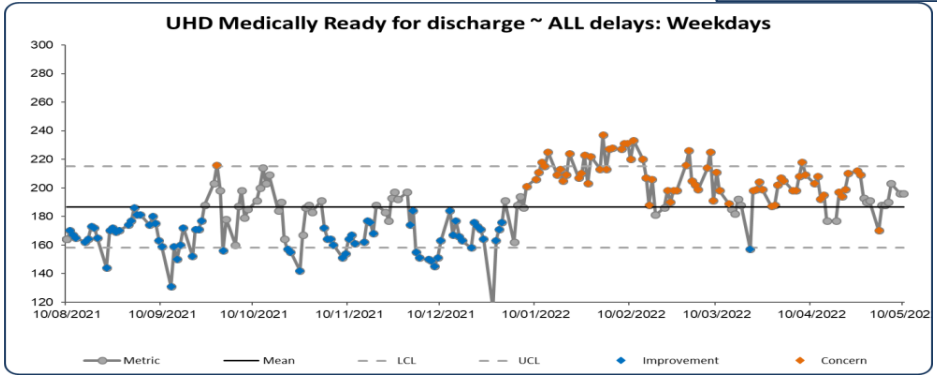
Criteria to Reside (excludes Ready to Leave)	Physiology	5%
	Function	12%
	Treatment	27%
	Recovery	8%
	Not Recorded	**48%**
Proportion of patients who are Ready to Leave		27%

High Level Trust Performance (weekly)









Escalation Report

Apr-22

Trauma Orthopaedics : 24% compliance achieved against fractured neck of femur target of 95% of clinically appropriate patients to surgery within 36hrs.

Activity | Response

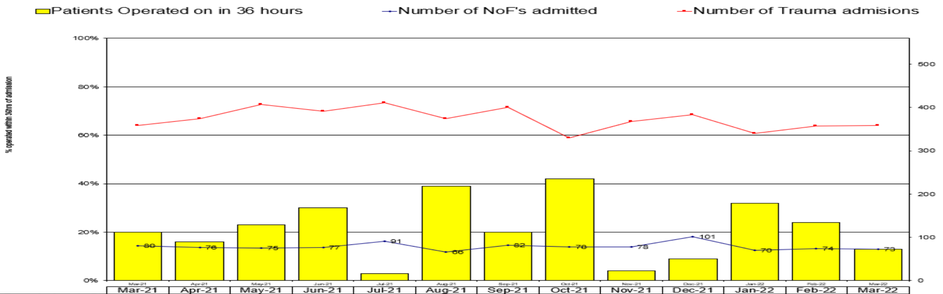
Definition of Trauma Quality Targets & Compliance Achieved

NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission.
Apr 2022 Compliance: 13%
CCG 2018-19 Quality Target: 95% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission or of being clinically appropriate for surgery, increasing to 95% by March 2019 (internal target remains at 95% on a monthly basis).
Apr 2022 Compliance: 24%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
Apr 2022 Compliance: 87%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	6
Patients on anti coagulants	0
Other NoF/trauma patients prioritised	47
Loss of weekend capacity due to theatre staffing	0
Awaiting x-ray/scan availability	0
Required medical review pre-op	1
Equipment failure	0
Awaiting specialist surgeon	3
Total breached NoFs	57

Demand on Trauma Directorate during March 2022



	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Patients Operated on in 36 hours	20%	16%	23%	30%	3%	39%	20%	42%	4%	9%	32%	24%	13%
Number of NoF's admitted	80	76	75	77	91	66	82	78	78	101	70	74	73
Number of Trauma admisions	358	374	407	391	411	374	401	330	368	384	340	357	358

Escalation Activity in Febuary 2022

a consintent number of patients admitted in April compared to March with 358 admissions including 73 patients with a fractured neck of femur (# NoF) and 10 with a femoral shaft fracture.
NHFD performance remains challenged with a reduction in our attainment of targets this month again due to a poor start to the month with 39 patients awaiting surgery on the first of the month and the 4 day holiday period over Easter.
the trauma service spent the majority of the month in stage 3 of escalation peaking at 60 patients waiting both as inpatients and at home, with several patients referred from clinic with 12 day old injuries which required prioritising over in patients.
the trauma service lost approximately 17 theatre sessions in April, compared to our pre Covid template.
Theatre staffing and radiographer availability continue to affect the availability and utilisation of our trauma lists. CSSD process continues to impact particularly over a weekend in April were wet theatre kits resulting in not enough kit available on site to operate on our patients requiring hip hemiarthroplasty.

Mitigations and Reset

.
Bi weekly Trauma Improvement group in place to review opportunity and blocks to safety, productivity and efficiency. Remedial action plan created and action log in place. April innaugral Trauma summit planned. Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate.
Virtual fracture clinic capacity increased to provide same day access.
Bed base, reduction in core capacity (108 to 89) to support Covid capcity and Critical Care capacity.
No overall change in average daily NOF admissions leading to backlog of patients awaiting surgery remains 3.25 per day.
Daily trauma escalation operational huddle in place.
Recruitment under way for consultant posts to support Derwent 3rd theatre and trauma capacity.
Trauma Ambulatory Care Unit (TOACU) opened at the end of July 80% admission avoidance rate improving to 90%. Service impacted over holiday period as capacity used for inpatient capacity for 3 days.
Service now had consistent ringfencing resulting in up to 40 pts/wk with admissions avoidance >80%.
High level of MRFD patients accross trauma (35%), liason and linking with Trust operational flow project ongoing.

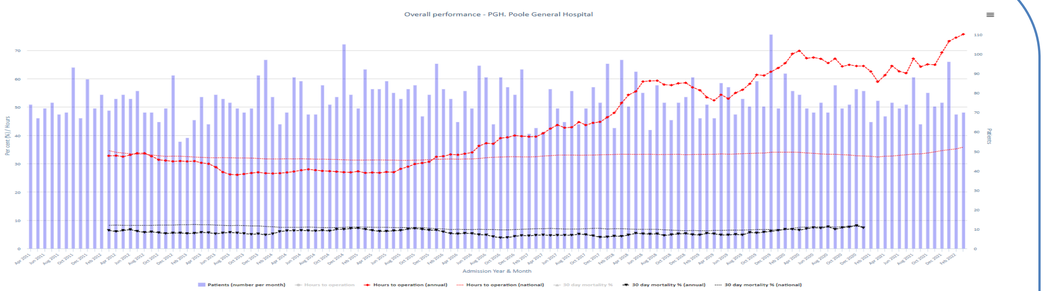
Complexity of Case Load

Soft Tissue	No. of pts
Patients requiring returns to theatre	15
Additional theatre slots required	19
Complex Surgery	No. of pts
Total Hip Replacements for NoFs	8
Revisions carried out	3

#NoF admissions presented relatively evenly spread through the month Easter was especially busy with 19 NoF's admitted in a 4 day period and although there was access to 3 theatre lists everyday other patients were clinically prioritised. 8 patients required a THR for their # NoF, 2 patients required full THR revisions and 1 required a revision PFN to THR for failure of PFN.

15 patients required 2 or more surgical interventions resulting in an additional 19 theatre visits with would equate to approximately 6 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

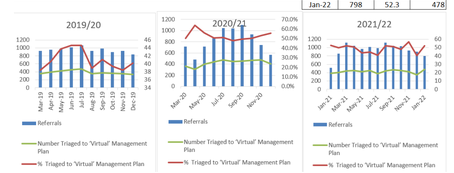
Neck of Femur QSPC Focus



Name	Code	Number of cases submitted	Case ascertainment: total cases compared to last year (%)*	Acute length of stay (days)	Overall hospital length of stay (days)	Documented final discharge destination	Discharge to original residence within 120 days	Hip fractures which were sustained as an inpatient*	Documented not to have developed a pressure ulcer	Documented not to have had a reoperation within 120 days*	120 day follow up
Poole General Hospital	PGH	891	96.7	15.9	16.1	100.0	69.8	2.4	90.8	70.4	82.2
Norfolk and Norwich Hospital	NOR	849	100.8	15.0	14.9	99.9	59.2	2.9	89.9	2.8	0.0
Leicester Royal Infirmary	LER	827	100.7	14.3	21.9	100.0	83.6	3.7	99.9	0.0	0.0
Queen Elizabeth Hospital, Edgbaston	QEB	803	91.8	13.5	15.7	97.5	56.2	2.6	99.9	0.0	0.0
University Hospital Aintree	FAZ	788	109.1	17.6	22.4	100.0	59.5	3.9	98.1	87.8	8.2

April Update on virtual fracture clinic

2019/20				2020/21				2020/21			
Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355	Jan-20	860	40.2	314	Jan-21	518	52.5	383
Apr-19	953	40.6	387	Feb-20	889	39	365	Feb-21	852	50	400
May-19	972	43.7	425	Mar-20	716	50.4%	361	Mar-21	1117	52.1	438
Jun-19	1012	44.6	451	Apr-20	484	63.6%	308	Apr-21	1039	50.6	452
Jul-19	1064	44.6	467	May-20	716	55.9%	400	May-21	972	43.7	425
Aug-19	926	38.9	352	Jun-20	861	50.8%	438	Jun-21	1012	44.6	451
Sep-19	988	41.1	375	Jul-20	1040	51.1%	473	Jul-21	988	41	375
Oct-19	899	39.4	365	Aug-20	1038	47.8%	448	Aug-21	1117	52.1	438
Nov-19	924	38.4	355	Sep-20	1100	49.3%	452	Sep-21	1040	51.1	473
Dec-19	832	40.2	332	Oct-20	934	50.3%	467	Oct-21	1038	47.8	448
				Nov-20	743	53.2%	478	Nov-21	928	56.8	425
				Dec-20	563	55.6%	403	Dec-21	899	40.2	345
								Jan-22	798	52.3	478



In comparison to 2019 activity there has been an increase in patients managed virtually, with up to 64% of all referrals managed as such. Over the comparable months there has been an over all increase to 55% versus 40% in 2019. This has undoubtably helped to mitigate demands on face to face fracture clinics and remains a huge success.

Author John West

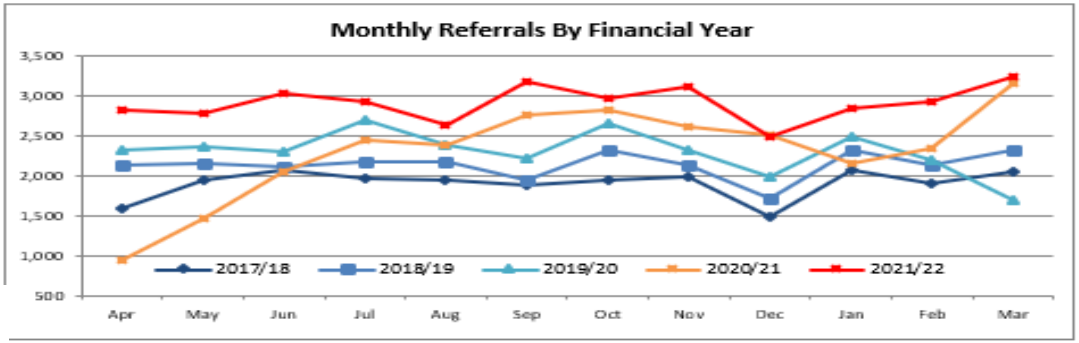
Cancer - Actual March 2022 and Forecast April 2022

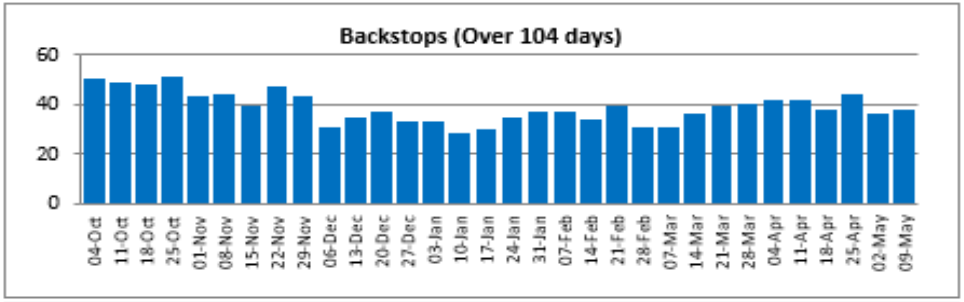
Commentary on high level board position

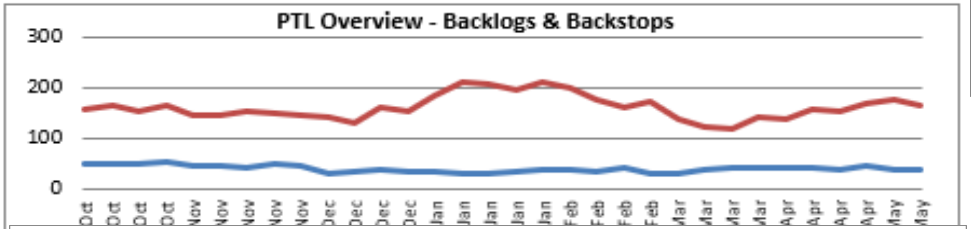
The overall rate of two week wait referrals in March 2022 were at similar levels when compared to March 2021. Sites seeing the highest increases in referrals in March were Lung (+57%), Urology (+28%) and Upper GI (+21%). Referrals in April were slightly below the number seen in April 2021. Lung was the only tumour site that saw a significant increase (+20%) in month. The total number on the UHD PTL continues to be just below 3000 and ranks 25th when compared nationally. Of the 30 trusts with the largest PTL's nationally, UHD has the 3rd lowest % of backstop patients and the 2nd lowest within the Wssex Alliance. The average number of patients waiting over 62 days in April was slightly below the trajectory by 5.5. 28-day FDS performance fell short of the 75% threshold reporting 73.3% which is a continued improvement when compared to previous month with 6 tumour sites achieving the standard. The provisional performance for April is 71.1%. Data completeness in March against this standard was above the target of 95% achieving 97.9%. The Trust has consistently achieved the 31-day standard and is expected to be achieved in April. 2 out of the 3 subsequent treatment KPI's were achieved in March with surgery falling short of the standard, mainly due to urology RARP capacity. The 62-day performance in March was below the 85% threshold (71.3%), however remains above the current national average of 70.2% with UHD ranking 66th out of 141 trusts (only 22 trusts out of 141 achieved the 85% threshold in March). Performance in April is currently at 71.1%.

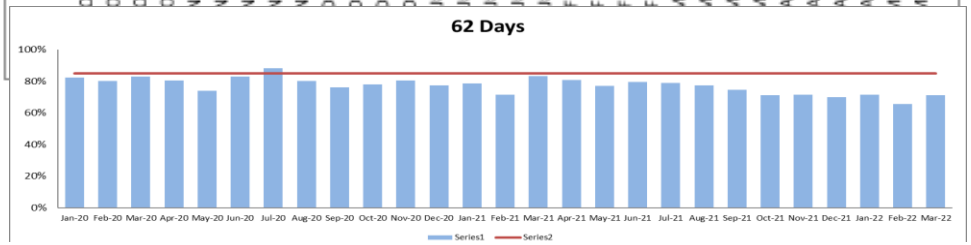
High level Board Performance Indicators & Benchmarking

Cancer Standards	Standard	UHD Mar-22	Predicted Apr-22
31 day standard	96%	98.3%	96.7%
62 day standard	85%	71.3%	70.3%
28 day faster diagnosis standard	75%	73.3%	71.1%

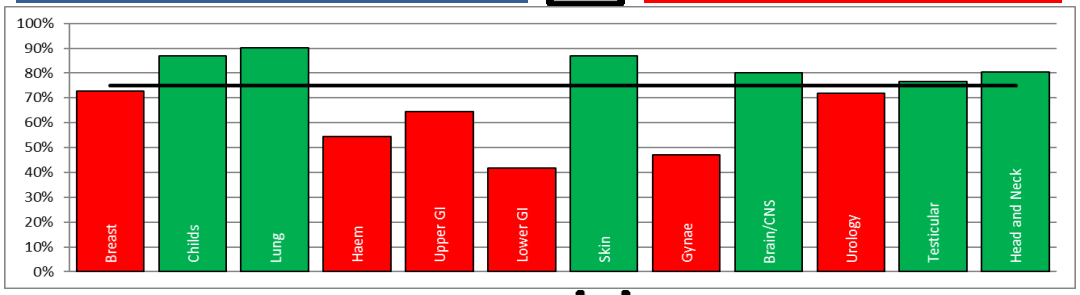




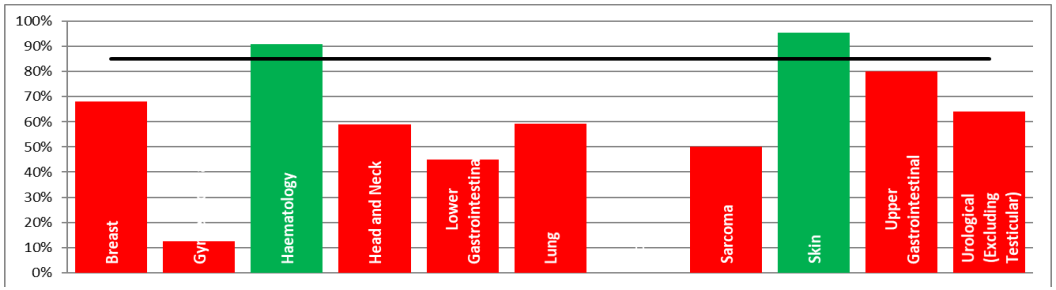




Target 75% | **28** | **UHD: March 2022: 73.3%**



Target 85% | **62** | **UHD: March 2022: 71.3%**



Elective & Theatres

Commentary on high level Board position

18 Weeks Referral to Treatment
At the end of April 2022, the Trust's 18 week RTT performance is **56.1%** (92% standard).

- 2,798 patients were waiting over 52 weeks for treatment, an increase of 143 compared to March. The percentage of the waiting list over 52 weeks has been maintained at **4.7%** .
- 759 patients are waiting over 78 weeks, an increase of 1 since March, and 238 patients are waiting over 104 weeks. The 104week wait position has reduced by 42 in April 2022.
- Specialty level improvement trajectories for longwaiters are in place and governed by the Care Groups with oversight of delivery through the Operational Performance Group.
- The overall **waiting list size** has grown in 21/22 and is 19% above the September 2021 position. Reduced capacity for elective care during the pandemic due an increase in Covid positive patients, high bed occupancy and workforce gaps have contributed to this position. The Trust is also experiencing a rise in referrals in some specialities.
- **99.7%** of patient referrals have been allocated a clinical prioritisation code (P code) .

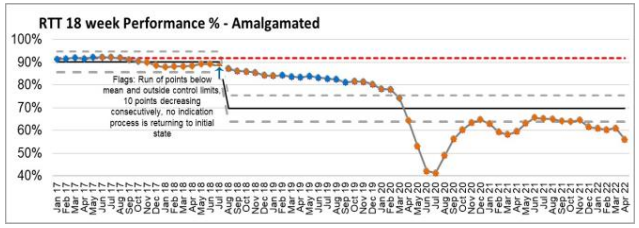
Theatre utilisation : update to follow
The current staffed theatre (main) utilisation rate has **remained 71%**. Daycase has redcued by 1% since last month to 62%.

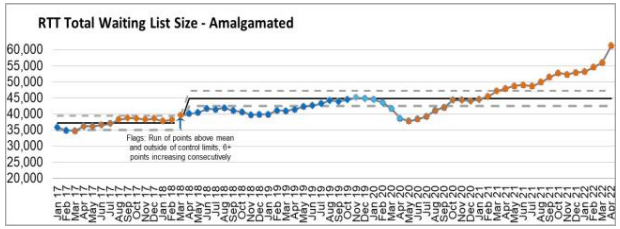
Trauma
The percentage of patients with a fractured neck of femur treated within 36 hours of admission has remained at 24%, an improved position compared to start of the quarter (9% January).

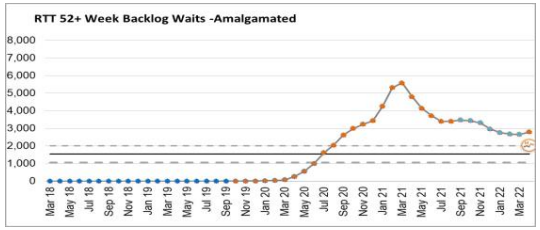
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	56.1%	
Waiting list size	51,491	61,278	19%
Waiting List size variance compared to Sep 2021 %	0%	19.0%	
No. patients waiting 26+ weeks		17,433	27%
No. patients waiting 40+ weeks		7,370	35%
No. patients waiting 52+ weeks (and % of waiting list)	4.6%	2,798	56%
No. patients waiting 78+ weeks		759	66%
No. patients waiting 104+ weeks		238	63%
Average Wait weeks	8.5	19.5	
% of Admitted pathways with a P code		99.7%	
Theatre metrics			
Theatre utilisation - main	80%	71%	
Theatre utilisation - DC	85%	62%	
NOFs (Within 36hrs of admission - NHFD)	85%	24%	

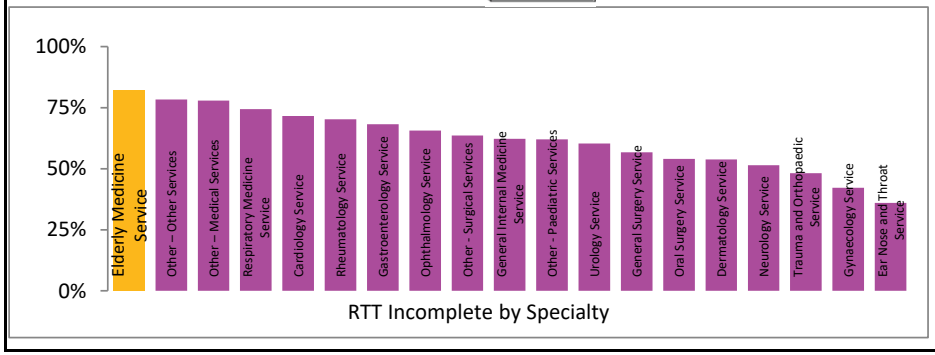
High Level Trust Performance



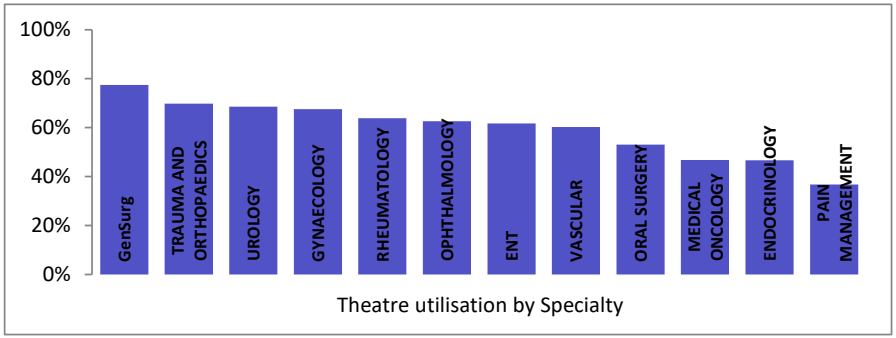




RTT Incomplete 56.1% <18weeks 18 WEEKS (Last month 61.0%) Target 92%



Theatre Utilisation 68.5% (Last month 68.4%)



Referral to Treatment (RTT)

What is driving under performance?

92% of all patient should be seen and treated within 18 weeks of referral.
56.1% of all patients were seen and treated within 18 weeks at the close of April 2022.
The overall waiting list (denominator) was **61,278** which is higher than previous months and 19% above the September 2021 waiting list of 51,491.

2,798 RTT waits exceeded 52 weeks, which is an increased position and above the Trust's operational plan trajectory for April 2022 (2,715).

April 2022 (compared with previous month)
34,353 increase < 18 weeks
17,433 increase > 26 weeks
7,370 increase > 40 weeks
2,798 increase > 52weeks
759 increase > 78 weeks
238 decrease > 104 weeks

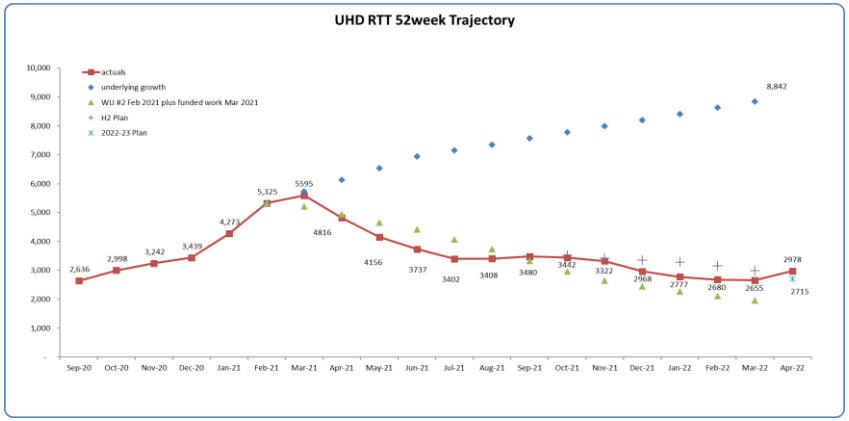
During March maintaining recovery of elective activity has remained a challenge alongside our continued focus on responding to COVID activity, managing an increase in demand, adhering to national guidelines on social/physical distancing, shielding and self isolation (patients and staff) and management of workforce capacity shortfalls in a number of areas. This has led to a reduction in routine elective activity including outpatient appointments and surgical procedures compared to 2019/20. The month also included Easter.

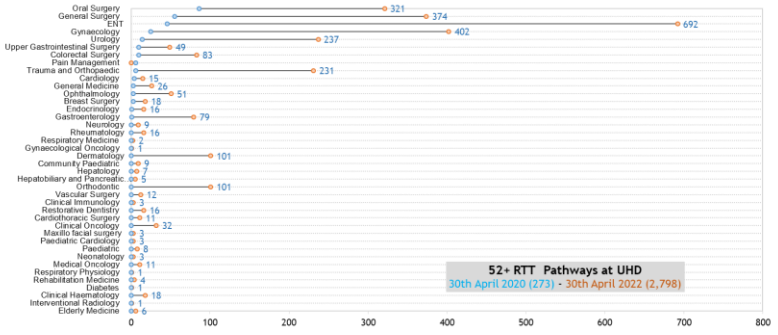
The Trust is currently working towards delivering a single, unified Patient Administration System (PAS) to better manage patient care across all our hospital sites. The impact of this managed change programme is that duplicate patient pathways will exist within the Patient Treatment List (PTL) for a period of time until administrative validation is complete and the duplicate removed. The presence of duplicate pathways is increasing the reported total waiting list position, RTT performance and number of >52 week waiters.

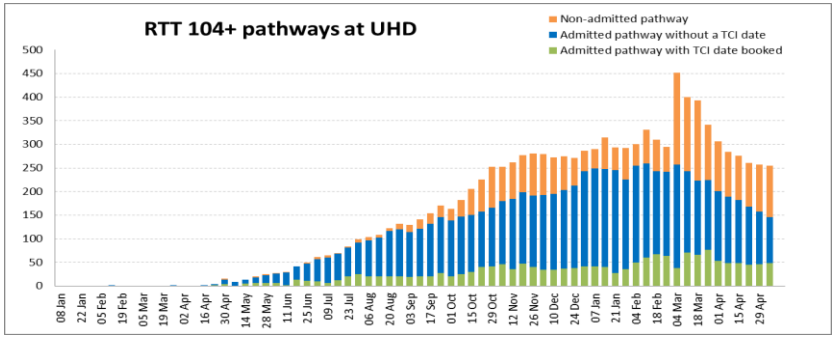
104 week-waiters improvement plan

To support ongoing reduction in the Trust of people waiting over 104 weeks, local recovery plans are in place and additional monitoring and tracking of improvement has been established.

An Elective programme is in place to oversee improvements in performance, activity and reducing the number of patients waiting a long time for treatment. The programme accounts to the Chief Operating Officer through the Trust Operational and Performance Group.







What actions have been taken to improve performance ?

Two Trust-wide improvement programmes are providing a foundation for improvements in elective care recovery:

- A **Theatre improvement programme** - to optimise theatre efficiency and utilisation and improve staff and patient experience of theatres
- **Outpatient Enabling Excellence and Transformation programmes - including three elements:**
  - Enabling Excellence programme - to deliver 'back to basics' improvements focused on achieving immediate and sustainable efficiency improvements in Outpatients
  - Digital Outpatients transformation, and
  - Outpatients Pathway Transformation programme - optimising use of virtual consultations, advice and guidance and patient initiated follow up pathways.

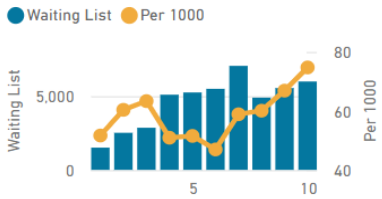
- We are also continuing the roll out plan to maximise use of high flow outpatient assessment clinics at Beales as part of the Dorset Health Village concept.

Health Inequalities
The Dorset Intelligence & Insight Service (DiiS) Health Inequalities dashboard enables analysis waiting times disaggregated by ethnicity and deprivation (Dorset Patients only).

Waiting list by Index of Multiple Deprivation (IMD)

Analysis of the waiting list by IMD identifies that 8.58% of the Trust's waiting list are patients living within the bottom 20% by Index of Multiple Deprivation (IMD). This increases to 9.6% when analysing patients waiting over 52 weeks and 9.9% of the waiting list over 78 weeks.

Total waiting list by IMD (Dorset only patients)



Waiting list by ethnicity

Where ethnicity is recorded 12% of patients are within Black and minority ethnic populations. This percentage is unchanged when analysing patients who have waited greater than 52 weeks.

Learning disabilities
Patients recorded as having a learning disability on the waiting list equate to 0.1% of the waiting list. This rises to 0.8% when analysing patients waiting over 52 weeks.

Executive Lead Mark Mould | Trust wide Lead | Author Judith May

6

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- GP Referrals are down on last year
- Patient cancellations have reduced compared to the previous month.
- The use of video/telephone consultations have reduced in month and are below the national standard in April. This may be a reflection of the casemix seen.
- An outpatients transformation programme is in place focussing on operational excellence, digital transformation of outpatient services and optimising use of virtual consultations, advice and guidance and patient initiated follow up pathways.

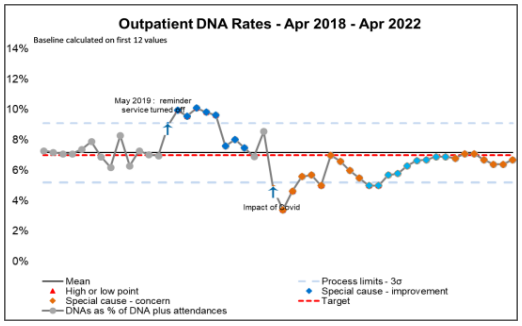
Diagnostics

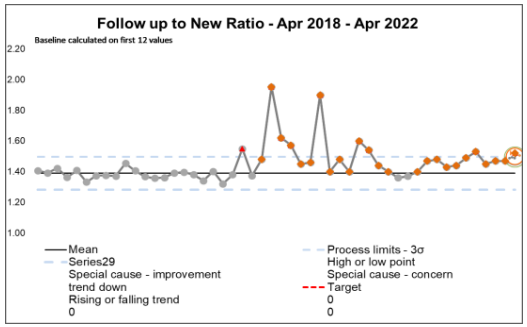
- Decrease against March position from 84.1% to 80.1% of all patients being seen within 6 weeks of referral.
- Endoscopy position has decreased from 62.7% in March to 55.6% in April
- Echocardiography has decreased from 58.6% in March to 52.8% in April
- Neurophysiology has decreased from 98.9% in March to 98.5% in April
- Radiology has decreased from 92.2% in March to 89.8% in April (planned recovery of MRI in May and CT in June 2022)

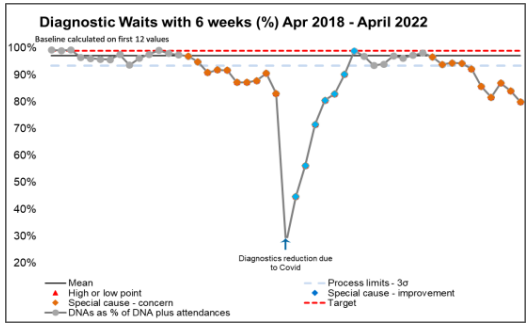
High level Board Performance Indicators & Benchmarking

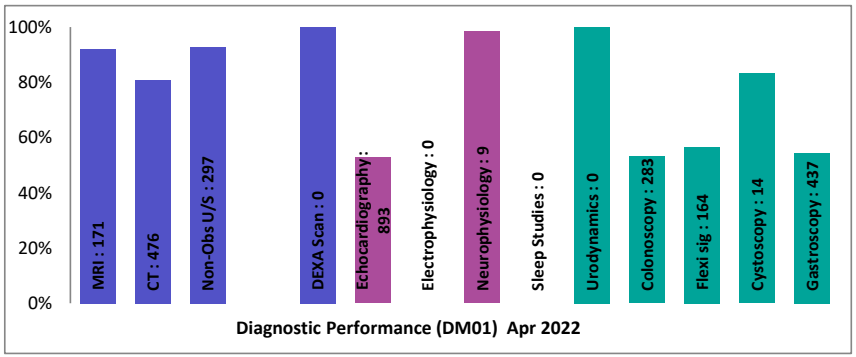
		Standard	21/22	22/23	Merged Trust
Referral Rates					
GP Referral Rate year on year		-0.5%	10794	8666	-19.7%
Total Referrals Rate year on year		-0.5%	19333	14643	-24.3%
Outpatient metrics					
Overdue Follow Up Appointments					46,566
Follow-Up Ratio		1.91			1.49
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%		28212 / 2025	6.7%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*			28212 / 4121	12.7%
Reduction in face to face attendances					
% telemed/video attendances	*(Total Atts / Total Non F-F)*	25%		28212 / 6765	24.0%
Diagnostic Performance (DM01)					
% of >6 week performance	*(Total / 6+ Weeks)*	1%		13755 / 2744	19.9%

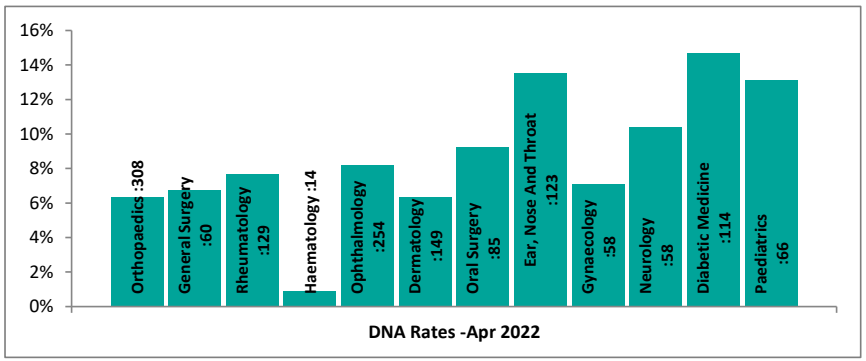
High Level Trust Performance











SCREENING PROGRAMMES

Commentary on high level board position

Breast Screening

The screening levels have increased considerably this month as long term sickness is coming to an end for some Radiographers and there are several bank Radiographers assisting with additional shifts.

Round length has remained stable at 40% for April depsite the fact that there have been equipment issues on the Dorchester mobile unit which resulted in a loss of over 250 screening slots.

The Screen to assessment KPI target was breached in April mainly due to the Easter break and annual leave but with the exception of the round length all other KPI targets are being met.

Based on the April data, if this screening activity is maintained, the service is on target to achieve recovery (90% round length) in July 2022.

High level Board Performance Indicators & Benchmarking

Breast Screening	Standard	Merged Trust
Screening to Normal Results within 14 days	95.00%	99.00%
assessment appointment within 3 weeks	95.00%	93.00%
Round Length within 36 months	90.00%	40.00%
Longest Wait time (Months)	36	40

SCREENING PROGRAMMES

Commentary on High Level Board Position

Bowel Cancer Screening

Age Extension

Age extension for the Dorset Programme was launched in May 2021 with invitations to 56 year olds and the bowel scope cohort.

The team are ready to invite 58 year olds in 2022/23. However, we have been notified by the Regional Commissioning team that the planned 'Go Live' date of 4th April has been delayed. The programme awaits confirmation of the new launch date .

Key Performance Standards

*** Uptake Standard** (*Number of subjects aged 60 to 74 who adequately participated in screening within 6 months of the invitation)*:

The average uptake rate was 74% through 2021 (acceptable performance = >52%; achievable performance = >60%). To date for 2022, uptake is averaging 71%.

*** SSP Clinic Wait Standard** (*Proportion of patients with an abnormal FIT result offered an appointment with a Specialist Screening Practitioner (SSP) within 14 days):*

The clinic wait standard has been maintained at 100% via virtual clinics (acceptable performance = 95%; achievable performance = 98%).

*** Diagnostic Wait Standard** *(Proportion of patients with an abnormal FIT result whose first offered diagnostic test date falls within 14 days of their SSP appointment)***:**

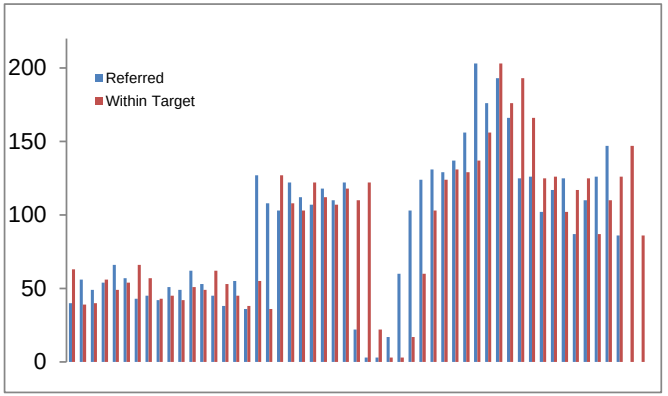
The diagnostic wait standard was not achieved at an acceptable level in February 2022 at 71%. This was due to the ventilation work on the RBH site that commenced in February and finished at the end of April. RBH BCSP activity was moved to weekend insourcing lists on the PGH site and some in week WLI lists. This has enabled the programme to recover the diagnostic wait position to 97% in March 2022 and 100% in April.

There is lower than anticipated screener availability on the RBH and PGH sites in May and June due to annual leave and ward commitments. However, the programme invitation rate has been reduced due to the delay in age extension to 58 year olds. Therefore the loss in activity will be mitigated with additional WLI lists if required.

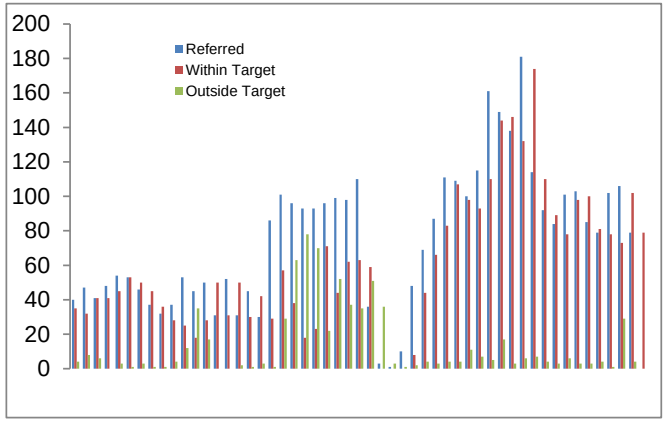
High Level Board Performance Indicators

Bowel Screening Standard	Target	Trust April Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	97%

Clinic Wait Standard



Diagnostic Wait Standard



FINANCE

FINANCIAL INDICATORS	Year to date		
	Budget	Actual	Variance
	£'000	£'000	£'000
Control Total Surplus/ (Deficit)	(2,304)	(3,986)	(1,683)
Capital Programme	16,925	14,240	2,684
Closing Cash Balance	73,925	86,420	12,495
Public Sector Payment Policy	95.0%	94.7%	(0)%

Commentary

Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who are medically ready for discharge. Within the Trust; both Emergency departments continue to operate under extreme pressure and we continue to care for over 200 patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate at Operational Pressures Escalation Level (OPEL) 4 with bed occupancy frequently exceeding 100%.

Operating under this pressure requires a relentless focus from all teams to ensure patients receive safe care. Having to operate under this pressure for such a sustained period has obviated the Trusts ability to progress transformation and efficiency schemes at pace. This has limited the Trusts ability to improve productivity and reduce expenditure and when compounded with the significant national workforce challenges and reduced COVID funding, makes it incredibly difficult to set a balanced budget. As a result, the Trust faces a very challenging year financially and has reluctantly set a deficit budget of £32.2 million. This deficit assumes full achievement of a very significant cost improvement programme of £27.4 million.

At the end of the first month, the Trust has reported a deficit of £3.986 million against a planned deficit of £2.304 million representing an adverse variance of £1.683 million. This adverse variance reflects the current shortfall in the cost improvement plan which requires immediate correction. Additional actions have been implemented to recover the current shortfall and mitigate against further slippage.

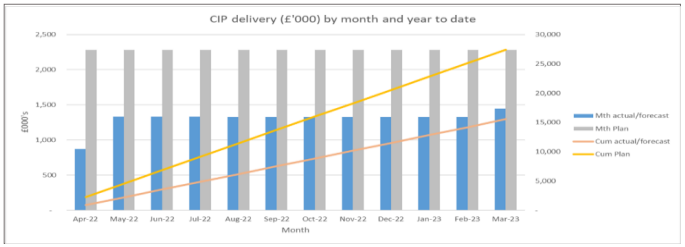
The Trust has set a full year capital budget of £122.1 million, including £94 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme enabling works. At the end of April the Trust has committed capital expenditure of £14.2 million against a plan of £16.9 million representing an underspend of £2.7 million. This underspend relates mainly to the New Hospitals Programme enabling works and the profile of spend against the new Pathology Hub. These programmes are expected to remain consistent with the full year budget albeit with some monthly variances throughout the year.

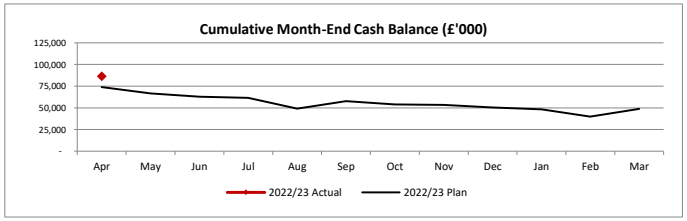
The Trust ended April with a cash balance of £86.4 million, all of which remains fully committed against the medium-term capital programme. The cash funding of this capital programme is now at risk given the in-year revenue deficit, and funding solutions will need to be explored to mitigate this.

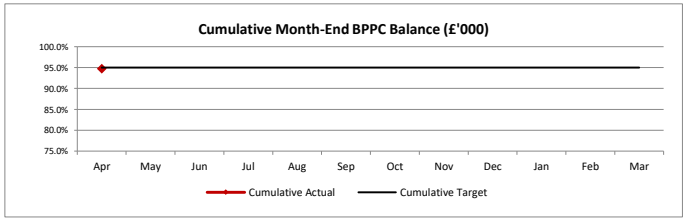
The Trusts payment performance remained strong in April, with over 94% of invoices paid within the agreed terms.

REVENUE	Year to date		
	Budget	Actual	Variance
	£'000	£'000	£'000
Surgical	(11,551)	(11,819)	(268)
Medical	(14,193)	(14,634)	(441)
Specialties	(14,888)	(15,120)	(233)
Operations	(1,899)	(2,029)	(130)
Corporate	(6,061)	(6,066)	(5)
Trust-wide	46,200	45,441	(759)
Surplus/ (Deficit)	**(2,392)**	**(4,227)**	**(1,835)**
Consolidated Entities	0	138	138
Surplus/ (Deficit) after consolidation	**(2,392)**	**(4,089)**	**(1,697)**
Other Adjustments	88	103	14
Control Total Surplus/ (Deficit)	**(2,304)**	**(3,986)**	**(1,683)**

CAPITAL	Year to date		
	Budget	Actual	Variance
	£'000	£'000	£'000
Estates	1,452	471	981
IT	613	145	468
Medical Equipment	145	106	39
Donated Assets	105	2	103
Strategic Capital	14,610	13,516	1,094
Total	**16,925**	**14,240**	**2,684**







Maternity

Commentary

Maternity incentive year four has been relaunched with additional safety guidance measures . The team are working on these standards and report back to board in Nov/Dec before submission in January.

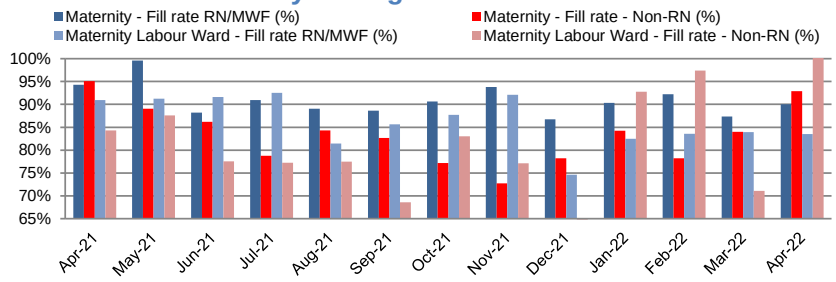
Midwives celebrated the international day of the midwives on May the 5th with a variety of activites throughout the day. Recognition was given to all staff on all the great work they do for women and families.

Maternity is reviewing the impact of SWAST Reap 4 status and the additional risks that this gives for women during labour and birth.We are working closely with SWAST and the regional chief midwife in completing through risk assessments and providing women with up to date information so that they can make informed decisions.

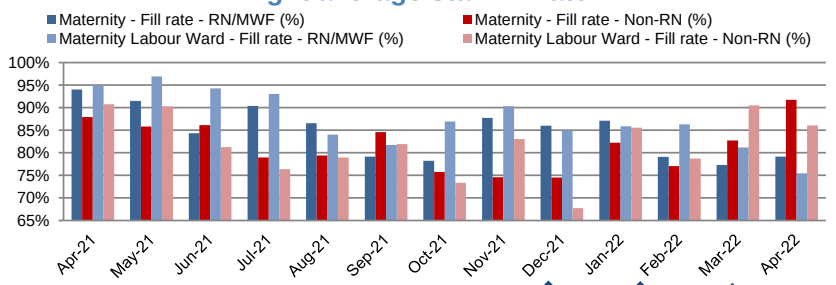
CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Outstanding	Good	Outstanding

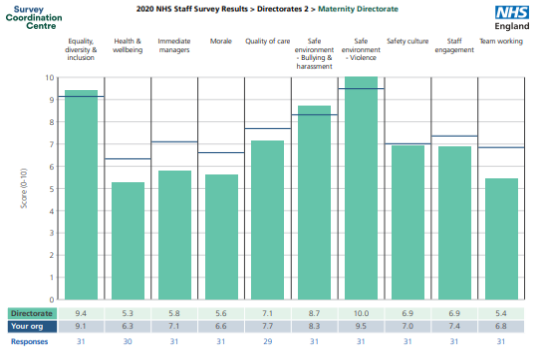
Screening incidences		2	
Serious Incidents Reported		0	
HSIB Cases Reported		0	
HSIB / NHSR /CQC Concerns		No	
Coroner Reg 28		No	
Maternity Safety Support Programme		No	
FFT Maternity User Response	Good / Very Good		
	Poor / Very Poor		
	Neither		
	Don't Know		

Day average staff fill rate



Night average staff fill rate





Training Compliance PROMPT Mar 2022

	Number Compliant Feb 2021 to date	Number of headcount Staff @ March 2022	Percentage Compliant
Midwives Band 5	16	18	88.88%
Midwives Band 6	153	173	88.43%
Midwives Band 7	27	30	90.0%
Midwiifery Managers, Matrons &Other Band 8+	5	7	71.43%
Consultant Obstetricians	15	17	88.23%
Obstetric Trainees (Doctors)	22	25	88%
Obstetric Anaesthetics	13	27	44.44%
HCAs/MCAs/MSWs	42	78	53.8%
ODP	10	13	76.92%

Maternity

HSIB Referal case (0)

Screening Incidents (2)

Severe Incidents (0)

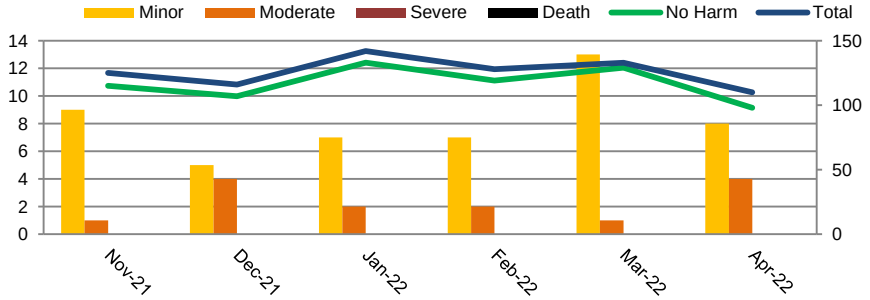
Perinatal Mortuary Review Panel

No new cases presented
1x case revisited following PM result
IUD 38 weeks gestation

Learning/Recommendations:

- Re-grading was agreed as a grade C (originally B), for antenatal care at another Hospital. This is to be fed-back to the relevant trust .
- Once actioned, relevant information to be disseminated to UHD's maternity risk team as to the reason for the re-grading
- UHD to undertake follow-up with patient

Datix Incidents



No Harm	115	107	133	119	129	98
Minor	9	5	7	7	13	8
Moderate	1	4	2	2	1	4
Severe	0	0	0	0	0	0
Death	0	0	0	0	0	0
Total	125	116	142	128	133	110

Learning from incidents (Recent HSIB Report)

Baby delivered in poor condition; transferred to NICU ventilated, therapeutically cooled and transferred to Tertiary Care Centre.

HSIB Safety Recommendations and actions:

- The Trust to ensure that all staff are supported to assess and implement safe staffing management plans that are well communicated and unambiguous.
- There had been enough staff for the birthing unit to be open during the night but not during the day of the incident. Although it is regrettable to have to move lower risk labouring women to labour ward it was suggested this may be necessary.
- Review of the escalation plan for such instances
- Trim Training/support ·
- The Trust to ensure there is a fully functioning alarm system, with a robust checking and maintenance programme, to enable staff to call for immediate help in any emergency.
- Staff toolbox talk on the emergency bell system, functions and testing (at least daily testing is the manufacturers recommendation).
- Implementation of process across all Maternity unit when the call bell is to be checked e.g. as part of the setup of the room before occupied by a patient
- The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance (RCPath, 2019).
- New policy in process being ratified. There are sluice posters for the placenta's to be kept. Staff education completed.
- When a baby requires NICU, placenta to be retained for 24 hours for the decision to be made.
- Share the information with the Neonatal Team.

Term baby admitted to NICU following a Category 1 Emergency Caesarean Section - No detectable heart rate at delivery, full resuscitation was given. Transferred to Tertiary Centre for therapeutic cooling

Learning and recommendations

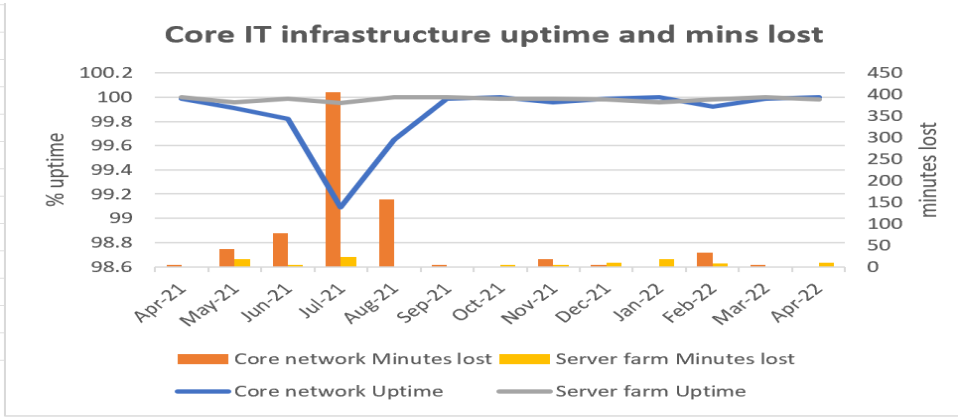
- In the absence of national guidance, the Trust to ensure that the local guidance provides senior clinicians with clear recommendations for the management of antenatal CTGs, with a focus on decision-making surrounding the appropriate mode and timing of delivery when the CTG is identified as being abnormal. ·
- The Trust to ensure that non-permanent members of staff are supported to access local electronic systems to ensure complete documentation of care delivered.
- The Trust to ensure that a holistic bedside review is undertaken by a senior obstetrician when antenatal CTG abnormalities are identified and a plan of care to be documented.
- The Trust to ensure that a process for escalation and prioritisation is in place when mothers need transfer to labour ward for continuous CTG monitoring, observation and senior midwifery oversight.
- Tripartite Debrief with HSIB and UHD arranged

Informatics - May 2022

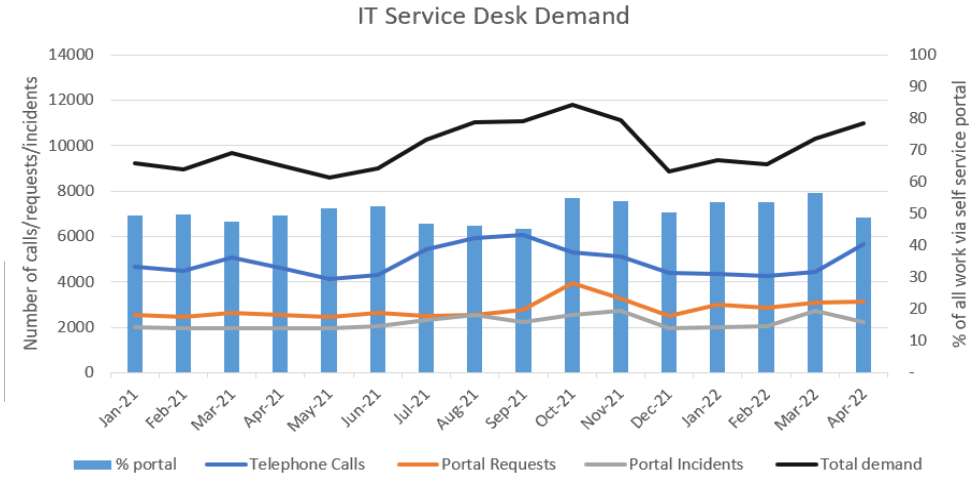
Overall Commentary: Graph 1: Core uptime: April figures show sustained optimum performance for core infrastructure. **Graph 2:** Service Desk demand uptick may relate to the retirement of Outlook 2010. **Table 5:** the unsupported Desktops figure has leapt to 81% as a result of Windows 10 (1909) becoming unsupported. A voluntary approach has been taken so far with 20% of the user base responding to that; we will now enforce the change over the next 6 weeks in a staggered way to avoid too much disruption. **Graph 6:** Compliance reset for 21/22 DSPT year, reflecting changing metrics. Ultimate compliance by 30/06/22 requires business support for IAOs to attend to their assurance tasks**. Table 7:** Compliance dipped, but in context of high number of requests for short month, ongoing OPEL level and sickness Trust-wide**. Graph 8:** DCR use shows a slight dip which relates to the working days in April (19) being significantly less than March (23), the daily use continues to grow.
Other project highlights: **Single PAS project:** has consumed all available resources within the Apps Support and IT training Team over the last few months. The go-live is planned for 17 May 2022.

Business As Usual/Service Management

Graph 1: core Infrastructure availability



Graph 2: Service Desk demand



Projects/Developments/Security/IG

Table 3: flow of Informatics projects since Nov 2018. c 150 closed projects per year.

Informatics Projects since November 2018						
Project Type	**Pending Approval**	**Not Started**	**Deferred**	**In Progress**	**Completed**	**Total**
eForm/Automation Project	2	10	7	42	200	259
Infrastructure Mandatory	0	0	1	4	27	32
Projects	15	45	10	78	315	448
Service Improvement Projects	0	0	0	0	3	3
Grand Totals	**17**	**55**	**18**	**124**	**545**	**742**

Table 4: Project Totals and Escalation

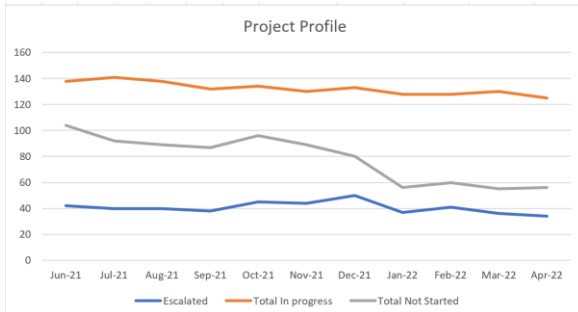


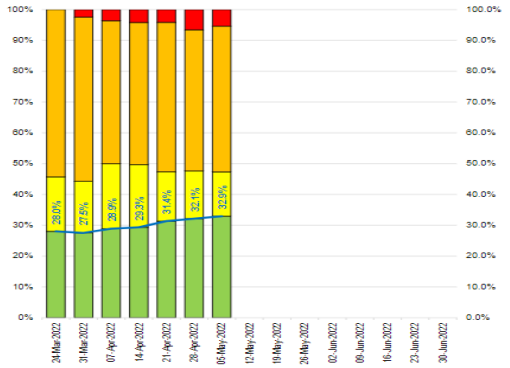
Table 5: Cyber Security - Obsolete systems

	Supported	Obsolete	Mitigated	Unsupported
Windows Desktops	19.2%	80.8%	0.0%	80.8%
Windows Servers	77.8%	22.2%	21.5%	0.7%

Table 7: FOI compliance

	Total rec'd	Compliance
December '21	51	76%
January '22	55	91%
February '22	57	77%
March '22	63	79%

Graph 6: Well managed Information Assets



Graph 8: DCR growth

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 7.4

Subject:	Mortality Report

Prepared by:	Alyson O'Donnell – Chief Medical Officer Divya Tiwari – Mortality Lead for UHD
Presented by:	Alyson O'Donnell

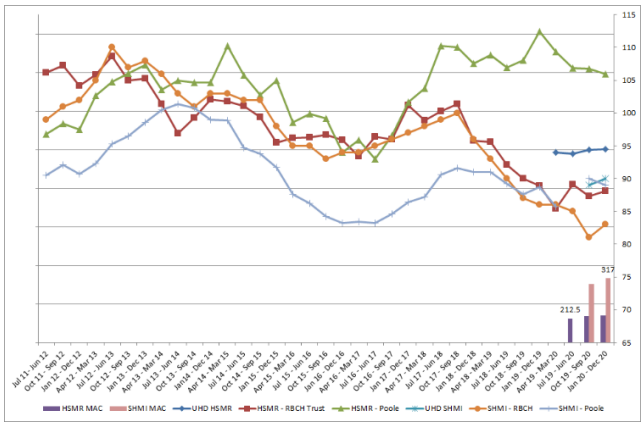
Purpose of paper:	This report advises the Board of the Mortality metrics within the Trust.
Background:	Mortality metric ratios and also gives an update on the Diagnostic and Procedural Alerts for the Trust.
Key points for Board members:	The Board is asked to note the improvement in mortality metrics and the outstanding areas of focus where there remains a higher relative risk including fractured neck of femur The Board is asked to note the ongoing work of the Mortality Surveillance group in investigating areas of high relative risk particularly between hospital sites
Options and decisions required:	None
Recommendations:	For information
Next steps:	For information

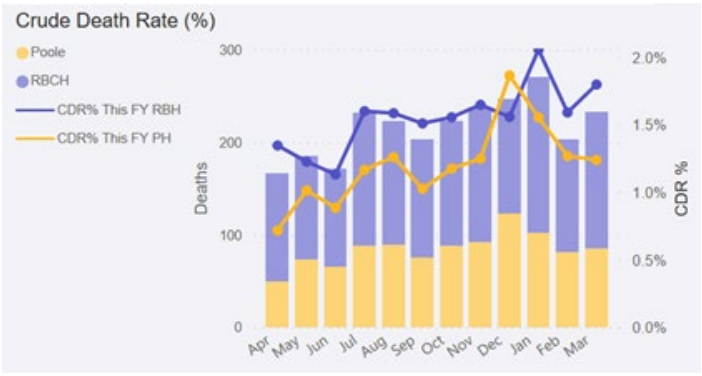
Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**

University Hospitals Dorset
NHS Foundation Trust

Chief Medical Officer's Report to the Board
Mortality Update





HSMR February 21 to January 22 (UHD) SHMI Jan 21 to Dec 21

Indicator	Site	Value	Range
HSMR	RBH	85.3	Better than expected
	Poole	98.5	As expected
	UHD	97.3	As expected
SMR	RBH	83.5	Better than expected
	Poole	93.8	As expected
	UHD	93.9	Better than expected
SMHI	RBH	84	As expected
	Poole	88	As expected
	UHD	90	As expected

Mortality Ratios

Mortality ratios are gaining statistical stability post 'Covid 19' mortality, however benchmarking is still complex due to variable Covid activity nationally and low admission rates for 'non-Covid' activity particularly in the month of April 2020.

UHD HSMR is within the expected range and SMR is in better than expected range. SHMI (one month behind) is also in the expected range. All mortality indicators for UHD are in the same range and therefore at UHD level there is no significant statistical variation. Finally, site level data has converged for all of the mortality indices (HSMR, SMR, SHMI), and there is no statistical variation within the indices. Poole site has all ratios within the expected range and Bournemouth has all ratios in the better than expected range.

There are no new Dr Foster diagnostic or procedural alerts, diagnostic alerts in Intestinal obstruction and Lower respiratory tract infections are under review.

The crude mortality ratios show fluctuating trends with variation on the two sites showing spikes in December and January mortality. Operational pressures during the winter months can create a so called 'wobble' and there is often correlation with acuity/'OPEL' grading/ bed occupancy and 'clinical outcomes' (mortality and morbidity).

Diagnostic and Procedural Alerts – Table 1

Dr Foster's Senior Analyst presented an intelligence report and alerts at the January MSG.

Dr Foster Alert	Type of Alert	Site	Action Plan	Completion Date
Fracture of lower limb	Diagnostic alert (CUSUM)	Poole	Study link with fracture neck of femur	Review linked to # NOF
Lower respiratory tract infection	Diagnostic (Relative risk)	RBH	Awaits mortality review	Under review
Intestinal obstruction without hernia	Diagnostic(Relative risk)	Poole	Combined RBH/ Poole review	December 2021 (report delayed)
Pneumonia	Diagnostic(Relative risk)	Poole	Case notes review	Review Complete, Action plan agreed
Total excision of bladder	Procedural (Relative risk)	RBH	Internal review Case	Review complete Action plan agreed
#NOF	Procedural alert(within expected for 12 month, very high for November and expected to climb)	Poole	Review complete	Initial findings discussed at MSG, action agreed
Tuberculosis	Diagnostic alert 2020	RBH	Case notes review	Review complete Learning disseminated

Mortality Review Related QI projects

<u>IV fluid management and prescription:</u>

This trust-wide QI group reported to MSG from the work undertaken and the targets achieved in 021/22. Dr Thavanesan presented the findings from 3 PDSA cycles and audits showing significant improvement in iv fluid prescription practices and improved compliance with NICE standards.

The electronic fluid balance chart development is ongoing, the IT team is resolving minor issues identified from the first pilot testing.

Acute Kidney Injury: annual review of high risk condition

Annual AKI service review and associated annual mortality led to three learning points and key lines of enquiries. The trust-wide QI group will be addressing the required improvement in 2022/23.

Learning from Deaths Review QI Project

This QI group is reporting to the CMO (MSG chair) and led by Jo Sims. Subdivided in many task and finish groups under supervision of Morgan Smith, who is tasked to transition paper based processes to electronic platform (e-fication) starting from death verification, mortuary transfer, Medical Examiner review and e-Mortality review across the whole of UHD. This will finally lead to the e-mortality review process being rolled out at Poole.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 7.6

Subject:	Reviewing Gender Pay

Prepared by:	Debbie Robinson, Equality Diversity and Inclusion Lead Lisa White, Head of HR Operations Carla Jones Deputy Chief People Officer
Presented by:	Deb Matthews, Director of Organisational Development

Purpose of paper:	To note the Gender Pay Gap of 6.62% and endorse the updated infographic and report to be published externally
Background:	The Gender pay gap is a mandatory requirement for all organisations with 250+ employees. The data was uploaded to the Gender Pay Gap service to meet the compliance standard by 31 March 2022. A full report and action plan must be reviewed and ratified by the Board of Directors and published on our external website.
Key points for Board members:	The Trust is required to report on snapshot data as at 31 March 2021. This data demonstrates that there could be greater female representation in senior clinical roles. The position is consistent with previous snapshot data taken from 31 March 2020 data. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles. 6.2 It should be noted that the 2020 data was first published in March 2021, and this latest data is from 31 March 2021. Therefore, the effectiveness of actions developed to reduce the gender pay gap will not be evident until 2023. 6.3 Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and gender representation. 6.4 Comparing the median hourly pay gap women earn 93p for every £1 that men earn. Their median hourly pay is 6.6% lower than men's. 6.5 Comparing the median bonus pay gap women earn 33p for every £1 that men earn. When comparing mean (average) bonus pay, women's mean bonus pay is 35.4% lower than men.
Options and decisions required:	The Trust Board is asked to review these data, note the contents of this report and endorse the actions.

Recommendations:	To approve the Gender Pay Gap report and recommend the updated infographic and report to be published externally.
Next steps:	The following actions are in place to further support the gender pay gap during 2022/23 • **Share the Gender Pay Gap -** include the data in the development of culture and workforce dashboards for all our Care Groups. • **Flexible working** – Raising the profile of the benefits of Flexible Working across UHD through a range of methods, including communication briefings, inclusive leadership conversations, management training. • **Career Progression -** Accessible bite sized and online training will continue, to ensure development can be accessed by those working part time and flexible work patterns. • Bias awareness is included in new leadership and development modules • **A Women's network** is being scoped, with interest from staff across the organisation. • **CEA awards** – Once national guidance is received on the reform of LCEA's a new award process will be developed for UHD. This will be more inclusive, transparent and fair and will reward excellence and improvement, underpinning the delivery of local priorities.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Be a great place to work
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well Led

Committees/Meetings at which the paper has been submitted:	**Date**
Workforce Strategy Committee	20 April 2022

Useful Abbreviations;

- BAME - Black, Asian and Minority Ethnic
- BME - Black Minority Ethnic
- EDI - Equality Diversity and inclusion
- EDIG - Equality Diversity and Inclusion Group
- WRES - Work Race Equality Standards
- WDES - Work Disability Equality Standards
- ICS – Integrated Care System

1. Background

1.1 It became mandatory from 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The results must be published on a government website, as well as the employer's own website (and remain there for 3 years).

1.2 Gender pay reporting presents data on the difference between men and women's average pay within an organisation. It is important to highlight the distinction between this and equal pay reporting, which is instead concerned with men and women earning equal pay for the same (or equivalent) work. Across the country, average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. Whilst a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower. The Regulations have been brought in to highlight this imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it. (NHS Employers. *Briefing Note: Gender Pay Gap Reporting retrieved* 2021-06)

1.3 University Hospitals Dorset NHS Trust published its first report in March 2021, following the integration of Poole Hospital and Royal Bournemouth and Christchurch Hospitals. This data was taken from a snapshot date of 31 March 2021.

1.4 The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows Trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. The Gender Pay Gap Six Indicators

2.1 An employer must publish six calculations showing their:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

Under national guidance, medical staff clinical excellence awards are included within bonus pay.

3. Methodology

3.1 The statutory calculations have been undertaken at the snapshot date of 31 March 2021, using the national Electronic Staff Record (ESR) Business Intelligence standard report. In line with NHS Employers guidance Clinical Excellence Awards and the approach taken to award them at UHD have been categorised as bonuses.

3.2 Pay includes: basic pay, full paid leave including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances and shift premium pay. (**Note: bonus pay is included, but only as a separate metric as one of the 6 key indicators we need to produce. The gender pay gap figure is calculated from hourly pay – which can only be ordinary pay, bonus pay is not hourly).**

3.3 Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child care vouchers), redundancy pay and tax credits.

4. UHD Workforce Context

4.1 The gender split within the overall workforce is 76.5% female and 23.5% male. The breakdown of the proportion of females and males in each banding is as set out below:

	Female headcount	Male headcount	Total headcount	Female	Male
1	26	39	65	40.0%	60.0%
2	1397	449	1846	75.7%	24.3%
3	934	185	1119	83.5%	16.%%
4	574	106	680	84.5%	15.5%
5	1382	254	1636	84.5%	15.5%
6	1210	232	1442	83.9%	16.1%
7	733	156	889	82.9%	17.1%
8a	143	75	218	66.2%	33.8%
8b	76	48	124	66.1%	33.9%
8c	16	8	24	55.0%	45.0%
8d	18	7	25	66.7%	33.3%
9+	7	5	12	62.0%	38.0%
VSM	5	11	16	30.0%	70.0%
Medical	542	623	1165	46.5%	53.5%
Unknown	3	5	8	37.5%	62.5%
Grand Total	7066	2203	9269	76.5%	23.5%

5. Results for UHD - 31 March 2021 snapshot

5.1 Gender Pay Gap Results

- Our headcount has increased since last year with 196 more female and 45 more males across UHD (31st March 2020 vs 31st March 2021).

- This year our Gender Pay Gap is 6.62%. This is a very small improvement on last year's reported figure of 6.72% and continues the positive trend following the organisational merger in 2020. In context, our gender pay gap is the lowest in Dorset hospital trusts (DHUFT 8.7%, DCH 9%).

- There is an increase in representation at senior Manager level (8a-8d) of female staff, related to the organisational restructure. This is a positive move towards equitable representation with our workforce demographics.

Mean and Median Pay Gap

- The gender pay gap for the Trust overall, is 6.62% This has slightly decreased from 6.67% reported in 2021.
- The mean gender pay gap for the Trust overall, is 21.81%. This has decreased from 22.82% reported for 2021.
- If the Medical and Dental workforce are excluded from the calculation, the Trust's mean gender hourly pay gap would be 0.65%, compared to 21.81%, reported overall for 2021. The Trust's median gender pay gap would be 8.02% in favour of female staff.

a) Average gender pay gap as a <u>mean</u> average

Overall

	Male	Female	% difference
Mean hourly rate	£21.43	£16.76	21.81%

Agenda for Change

	Male (AFC)	Female (AFC)	% difference
Mean hourly rate	£15.41	£15.51	0.65%

Medical

	Male (medical)	Female (medical)	% difference
Mean hourly rate	£37.52	£32.25	14.05%

b) Average gender pay gap as a median average

Overall

	Male	Female	% difference
Median hourly rate	£16.15	£15.09	6.55%

(Note small variation from published overall GPG figure, due to recalculating with the staff group breakdown)

Agenda for Change

	Male (AFC)	Female (AFC)	% difference
Median hourly rate	£13.13	£14.28	8.02%

Medical

	Male (medical)	Female (medical)	% difference
Median hourly rate	£36.82	£27.58	25.09%

5.2 Clinical Excellence Awards Bonus Payments

5.2.1 Local Clinical Excellence Award's (LCEA) recognise and reward NHS consultants in England, who perform over and above the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions.

During the pandemic LCEA rounds were suspended and funding distributed by way of annual one-off non-consolidated, non-pensionable payments to all eligible consultants. This was delivered by giving a per capita allocation to all Consultants irrespective of whether full or part time. Existing LCEAs remain pensionable and consolidated.

During the last two years, NHS Employers have been working in partnership with the British Medical Association, to negotiate changes to the LCEA's effective from 1 April 2022. Unfortunately, both parties report that agreement on a package of reform has not been reached.

It is likely that the current system will change from Clinical Excellence awards to clinical impact awards but how these will run and how they will impact is not yet clear.

The calculations below include both local and national CEA's and the one-off non-consolidated payments made by the trust during the pandemic. The National CEAs are determined externally and administered by the Department of Health whilst Local CEAs are administered within the Trust on an annual basis.

5.2.2 Overall, there is a large differential between the amount of CEA bonus pay for medical staff with 20.7% of male medics receiving CEA pay in comparison to 10.5% of female medics. The average annual CEA pay being just over £11,626 for male medics compared to £7,502 for female medics.

The payment of existing CEA awards is pro-rata. However, agreement was reached with the Joint Local Negotiating Committee that non-consolidated payments would not be pro-rata. The lower payments received by some female medics relate to long term sick leave, maternity leave and leaving UHD part way through the year.

This is the first year the data has been further analysed for CEA awards for UHD.

Further detail and information on next steps with regards to the 2022 CEA scheme is awaited. In reforming the CEA scheme, the aim is to ensure that it is more inclusive, transparent and fair and encourages and rewards excellence and improvement, underpinning the delivery of local priorities.

c) Average Clinical Excellence Awards bonus gender pay gap as a mean average (medical)

	Male (Medical)	Female (Medical)	% difference
Mean bonus pay	£11,626.89	£7502.61	35.47%

d) Average Clinical Excellence Awards bonus gender pay gap as a median average (medical)

	Male (Medical)	Female (Medical)	% difference
Median bonus pay	£9048	£3015.97	66.7%

e) Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

Male proportion receiving bonus	Male medical staff overall	%	Female proportion receiving bonus	Female medical staff overall	%
129	623	20.7%	57	542	10.5%

5.3 Proportion of Males and Females in each Quartile Pay Band

5.3.1 At the time the snapshot was taken the percentage of female staff was 76.5% female and 23.5% male. As shown in the tables below, this percentage split is broadly mirrored in the lower, lower middle, and upper middle quartiles.

f) Proportion of males and females in all staff groups when divided into four groups ordered from lowest to highest pay

	Male %	Female %
Lower	22.16%	77.84%
Lower Middle	22.34%	77.66%
Upper Middle	15.89%	84.11%
Upper	35.27%	64.73%

g) Proportion of Agenda for Change males and females when divided into four groups ordered from lowest to highest pay

	Male %	Female %
Lower	22.45%	77.55%
Lower Middle	22.55%	77.45%
Upper Middle	15.69%	84.31%
Upper	18.71%	81.29%

h) Proportion of Medical staff males and females when divided into four groups ordered from lowest to highest pay

	Male %	Female %
Lower	46.42%	53.58%
Lower Middle	46.08%	53.92%
Upper Middle	54.14%	45.86%
Upper	67.57%	32.43%

For Medical and Dental staff, there are a higher proportion of males in the highest paid quartile.

i) Average (mean) Gender Pay Gap per quartile – Medical and Dental

	Male	Female	% difference
Lower	£18.78	£18.35	2.32%
Lower Middle	£26.45	£25.73	2.70%
Upper Middle	£41.20	£40.52	1.65%
Upper	£54.87	£54.27	1.08%

j) Median Gender Pay Gap per quartile – Medical and Dental

	Male	Female	% difference
Lower	£19.48	£19.29	0.95%
Lower Middle	£26.45	£25.75	2.63%
Upper Middle	£42.02	£41.41	1.47%
Upper	£53.07	£51.59	2.79%

6. Conclusion

6.1 The Trust is required to report on snapshot data as at 31 March 2021. This data demonstrates that there could be greater female representation in its senior clinical roles. The position is consistent with previous snapshot data taken from 31 March 2021 data. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles.

6.2 It should be noted that the 2020 data was first published in March 2021, and this latest data snapshot took place on 31 March 2021, as per the regulations. Therefore, any effectiveness of actions in place to reduce the gender pay gap will not be evident until at least the next gender pay gap publication.

6.3 Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and gender representation.

6.4 Comparing the median hourly pay gap women earn 93p for every £1 that men earn. Their median hourly pay is 6.6% lower than men's.

6..5 Comparing the median bonus pay gap women earn 33p for every £1 that men earn. When comparing mean (average) bonus pay, women's mean bonus pay is 35.4% lower than men.

7. Update on 2021 Actions

7.1 The following actions continue to support closing the gender pay gap:

Action Plan 2021	Progress
Share Gender Pay Gap information across the Trust	Published on intranet and internet. Shared with Care Groups
Develop a values proposition for employee life cycle/support	This is part of a wider project, still in development phase
Commit to values-based shortlisting and interview questions	Now embedded into the recruitment process
Refreshed recruitment and selection training to include values and more details unconscious bias content	Implemented in 2021, staff inclusion networks consulted and contributed to the training programme
Continue the Trust's commitment to an equitable workforce	Trust objectives and values
Continue equitable access to trust leadership training and development	On-going leadership programmes and additional capacity through the Dorset Integrated Care System for underrepresented groups
Support all staff in protected groups through living our Trust values and implementing our people strategy	Trust objectives and values. Staff inclusion networks People Strategy Flexible Working policy

8. Next Steps

8.1 The following actions are in place to further support the gender pay gap during 2022:

- **Share the Gender Pay Gap** - include the data in the development of culture and workforce dashboards for all our Care Groups.

- **Flexible working** – Raising the profile of the benefits of Flexible Working across UHD through a range of methods, including communication briefings, inclusive leadership conversations.

- **Career Progression** - Accessible bite sized and online training will continue, to ensure development can be accessed by those working part time and flexible work patterns.
  Bias awareness is included in new leadership and development modules.

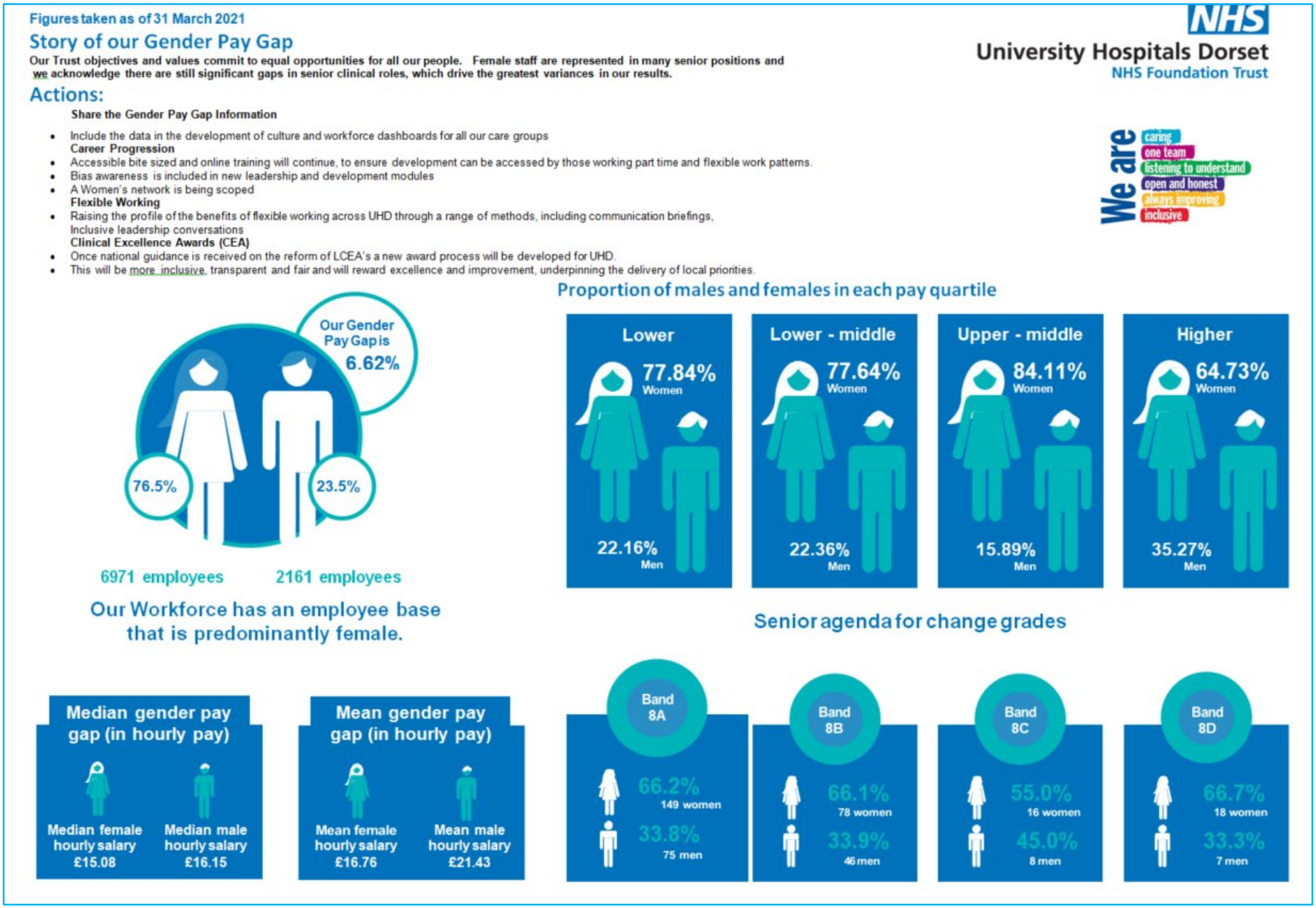
- **A Women's network** is being scoped, with interest from staff across the organisation.

- **CEA awards** – Once national guidance is received on the reform of LCEA's a new award process will be developed for UHD. This will be more inclusive, transparent and fair and will reward excellence and improvement, underpinning the delivery of local priorities.

8.2 The Chief People Officer/Director of OD will continue to work with the Executive team to support the identified actions. Delivery of these will be supported by the Trust's Equality, Diversity and Inclusion Group (EDIG) and assured through the Workforce Committee.

6 April 2022
Debbie Robinson, Equality, Diversity and Inclusion Lead

Appendix A: Infographic



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.1

Subject:	Freedom to Speak up; Annual Report 2021/22

Prepared by:	Helen Martin, Freedom to Speak up Guardian (FTSUG)
Presented by:	Helen Martin, FTSUG

Purpose of paper:	The purpose of this paper is to;
	• celebrate our progress in creating our speaking up culture over 2021/22.
	• understand why our staff are raising concerns and what we have learnt.
	• **ACTION**
	  ○ to commit to complete NGO/HEE the third and final module in the Freedom to Speak Up e-learning training package: Follow up
	  ○ Approve FTSU policy outlining interim changes (appendix A) until final publication of the revised Universal FTSU policy.
	• **To note** section 2.1 for consideration: development of a FTSUG deputy role.

Background:	This annual report goes to the Workforce Strategy Committee (April 20th), TMG (17th May) outlining speaking up activities and concerns being raised to the FTSU team.
Key points for members:	Themes and trends 2021/22 • The number of referrals to the FTSU team has maintained its activity to that seen in 2020/21 following a number of year on year increases. • Forty-four per cent of referrals come from staff at our Poole site and 56% from RBH. • Five per cent of referrals to the FTSU team were made anonymously (12staff) which is an increase from last year (↑4%) but continues to be lower than that seen nationally (13%). • Staff approach the FTSU team for a number of reasons. The greatest theme had an element of attitudes and behaviours (47%). This is following by process and procedures (33%) and then workload and burnout (12%). • Eight percent of cases have an element of safety whether that be staff or patient safety. All these issues were escalated, often to executive level. • The cases relating directly to COVID have decreased from 39%, same period 2020/21, to 7%. These cases often have elements relating to isolation and vaccinations.

	• When staff come to the FTSU team, there are a number of routes taken. In 34% of cases staff are empowered to escalate the issue to their line manager to investigate and action. In 41% of cases, referrals are signposted to our experts such as HR, OH or other experts. In 8% of referrals they were escalated by the FTSUG to director or executive level. • The largest workforce speaking up to the FTSU team are our nurses/midwives (34%), followed by our Administrative staff and Allied Health Professionals (each 19%) • Fourteen per cent of staff (33 staff) who raised a concern across UHD are from a BAME background • The proportion of referrals relating to attitudes and behaviours is significantly higher than compared to non-BAME staff. Seventy per cent (23 staff) report an element of behaviours as compared to 47% of all staff (109 staff) over the same period. • Staff across all areas of UHD use FTSU with Specialties having the highest number (74), followed by Medicine (57) and then surgery (38). • Four key observation of our learning from concerns over this time are o Compassionate and Inclusive leadership and People Management o Being Visible and Present o Developing a civil and respectful culture o Team integration
Options and decisions required:	**ACTION**: • Senior Leaders to commit to complete NGO/HEE the third and final module in the Freedom to Speak Up e-learning training package; Follow up • Approve FTSU policy outlining interim changes (appendix A) until final publication of the revised Universal FTSU policy
Recommendations:	• Speaking up is everyone's business • Promote the HEE/NGO e-learning Speak up, Speak up, Listen Up and follow up programme • To invite more local level discussions at our clinical care groups
Next steps:	Bi- annual report (Sept 2022) to Board

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
Workforce Strategy Committee	20th April 2022
Trust Management Group Committee	17th May 2022

Freedom to Speak Up (FTSU)

Annual Report 2021/22

1.0 Introduction

Speaking up is a gift – use it wisely and we can change the NHS for the better"

NGO Annual report 2021/22

Six years have passed since the publication of the Francis Freedom to Speak Up Review. The speaking up culture within the health sector in England has changed with a network of over 700 Freedom to Speak Up Guardians (FTSUG) in over 400 organisations hearing over 50 000 cases in the last 3 years. Such an increase of cases reflects how trusted FTSUG are as additional channel for speaking up.

The FTSUG cannot however work in isolation and our senior leaders play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture. The FTSUG can bring a significant source of support for leaders, supporting with the themes of what workers are speaking up about. The insights that the FTSUG can bring are important to help understand the behaviours and culture that workers experience in practice. These insights can highlight the challenges and act as an early warning system of where failings might occur. Recent, high profile cases within and outside of healthcare, have highlighted the consequence of not embracing speaking up in this spirit, and the truth has been silenced. The starting point is to listen with compassion and embrace speaking up as a means of learning and improving. Speaking up is everyone's business.

Speaking up at University Hospital Dorset (UHD) is the cornerstone of our culture as a new trust. This is reflected in our new set of values following the cultural review undertaken by our cultural champions. Our people clearly described the need for a learning rather than blame culture, whereby we are able to make mistakes without feeling afraid to discuss them. Psychological safety and feeling confident to speak up were seen as contributing to safer, excellent quality care. As a result UHD are proud to have "I will be open and honest" as one of our values.

This annual report reminds us that our people are speaking up across all sites of UHD, endorsing the significant steps that we have so far taken to creating a healthy speaking up culture. This will not only protect our patients but also improve the experience of our NHS workers.

The purpose of this paper is to;

- celebrate our progress in creating our speaking up culture over 2021/22.
- understand why our staff are raising concerns and what we have learnt.
- **ACTION**:
    - Senior Leaders to commit to complete NGO/HEE the third and final module in the Freedom to Speak Up e-learning training package; Follow up (refer to section 3.7.3).
    - Approve FTSU policy outlining interim changes (Appendix A) until final publication of the revised Universal FTSU policy.
- **To note**: section 2.1 for consideration: development of a FTSUG deputy role.

2.0 Vision of Speaking up and Commitment from the FTSU team

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

The Freedom To Speak Up commitment

S You're safe and secure to talk to us; we'll support you every step of the way to raise concerns.

P We are all about our people. When we look after each other we give the best to our patients. FTSU are here for you and hearing your voice is our priority.

E We treat all staff equally, empower you to make concerns and enable the trust to make change.

A We will listen and act with integrity to ensure your concerns are heard. We are approachable and here for you.

K We treat you kindly; we know what steps need to be taken when you raise a FTSU concern, we have the knowledge to help make a difference.

2.1 Speaking up at UHD – A new structure following NGO guidance (2021)

In April 2021, the NGO published guidance on developing FTSU internal networks. UHD has had a FTSU network since 2018, set up to raise awareness and promote the value of speaking up, listening up and following up. This network has helped address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

The NGO guidance has however needed us to reflect on how we work together separating out our roles more clearly with the FTSUG setting strategic direction and hearing cases and

limiting our FTSUA to raising awareness, signposting and support. This model does however pose limitations to a sole individual handling cases. In addition, this report will also show that UHD uses this channel for speaking up more than an average trust resulting in the FTSUG working in a more reactive rather than proactive way which was not supported by the recent FTSUG survey (refer to sections 3.7.2 and 3.7.5). The NGO are clear in reporting that speaking up will not become "business as usual" if the FTSGU is spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place.

Further exploration on how best to reduce these risks needs to happen and includes considering the development of a sustainable deputy role. The FTSUG chairs our Dorset Network and further afield across the south west and these conversations are happening where it appears that a number of trusts looking into this very issue.

To note for consideration: development of a FTSUG deputy role.

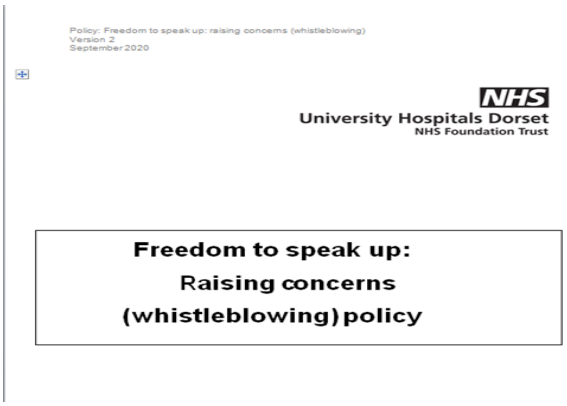
3.0 Key Progress during 2021/22

3.1 Speaking up Governance at UHD; Interim FTSU team

Interim members of the board have been welcomed to the FTSU team until either substantive post holders are in place or positions recruited. The FTSUG remains fully supported by the board and speaking up arrangements with direct access continues to be in place. It is anticipated that key board posts will be in place over the next couple of months and will be reflected in the new speaking up policy.

In November the board also publicly committed to the Sir Robert Francis principles of speaking up alongside a declaration of their behaviours. This annual commitment is a visual statement, supporting the vision of speaking up and by committing to developing a culture of safety. The declaration of behaviours sets out how we will role model this and sets the tone of the culture for the new trust.

3.2 UHD Speaking up Policy - interim



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ACTION for BOARD: Approval of interim Speaking up policy until final publication of the revised Universal FTSU policy.

Our interim speaking up arrangements are reflected in our amended Freedom to speak up: Raising concerns (whistleblowing) policy. There are also amendments following conversations with our audit committee requesting clearly clarification on how to escalate concerns relating to fraud or corruption. seen as a critical aspect of becoming UHD.

UHD are proud to confirm:

- Interim Non-Executive Director: Pankaj Dave
- Chief Executive, Siobhan Harrington (as of 1st June 2022)

Both roles are key sources of advice and support for their FTSUG and will meet regularly.

3.3. National Guardian Office (NGO) visit to UHD Board

In November 2021, the board welcomed the NGO to one of their development sessions. They presented the national picture and the challenges ahead, focussing on UHD and how it can continue to improve. The NGO recognised that UHD has an embedded speaking up culture and celebrated the established FTSU service as one of these channels for staff to raise concerns. There was debate that this route remains above average for similar Trusts and it was agreed that the team should be curious as to why this is. Speaking up should be everyone's business and that staff should be encouraged to approach our line managers in the first instance. Section 2.7.2 reports initial data for this.

3.4 FTSU Networks

Our networks are key to our success in sharing the speaking up message but also as a support for each-other. We have several networks which continue to grow and mature.

Our FTSUA network meets monthly and discusses our observations and recent guidance. It allows us to quality assure the work we are doing and more recently focus on updating and

reviewing the model going forward. We have planned a programme of work for 2022 including quarter key focus topics. These are:

- Qtr 1 – Speaking up is everyone's business
- Qtr 2 – Hearing everyone's voice
- Qtr3 – Developing a civil and respectful culture
- Qtr 4 – How do we develop a psychologically safe working environment?

The NGO also recognises the need to develop and engage within formal regional networks. The FTSUG was elected as co-chair of the southwest FTSU region in 2020 and chairs quarterly regional meetings, six weekly check ins and mentoring for new guardians. This network is excellent for support and sharing good practice.

The FTSUG also set up and chairs a local Dorset FTSU Network since September 2018. The vision of this group was agreed to share best practice, look to act as a mentor for difficult cases. The membership has since expanded and now has representation across CCG, private healthcare, ambulance service, acute trusts and our regional lead for NGO. The focus of these meetings has consequently changed to supporting speaking up across our multi-agency systems in Dorset.

3.5 UHD FTSU APP development

A development in 2021 was the launch of FTSU on our UHD app. We are proud to be on the landing page of the UHD app sending a clear message of how important speaking up is for our people. In this app, there is information about speaking up but alongside this, a facility to refer (including anonymous) concerns to the FTSU team. Whilst it is always preferred that our people share their identity so that the issue can be explored fully, the staff member properly supported, and it allows feedback, this is not always the case. Other Trusts use external suppliers to do this whereas we have been able to develop this alongside our app developers. Staff are starting to use this route of referral and can partly explain the increase of anonymous feedback this year (refer to section 4.1).

3.6 Speaking up Month – October 2021 Reflections

Speak Up Month is the highlight of our calendar and is a chance to raise awareness of Freedom to Speak Up and the importance of speaking up. The national theme of this year's Speak Up Month was "Speak Up, Listen Up, Follow Up" so that when people speak up, they are listened to, and that both learning and improvement happens as a result. Weekly key messages were released during our speaking up month at UHD. These messages included why speaking up is important, information of the national e-training modules found on our BEAT system, the new way to make a referral (including an anonymous facility) using the new @UHD and how to create a civil and respectful culture. Alongside this, there was a refresh and launch of literature including new banners, videos and screensavers. The Freedom to Speak up Guardian (FTSUG) also got out and spoke to staff. We saw a spike in our referrals in November which illustrates the importance of this campaign and raising the importance of speaking up.

Freedom to Speak Up Annual report; 2021-22
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3.7 National Guardian Office (NGO)

3.7.1 New National Guardian

Dr Jayne Chidgey-Clark was appointed as our new National Guardian as of 1st December 2021 following the stepping down of Dr Henrietta Hughes in the Summer.

Dr Chidgey-Clark is a clinical leader and registered nurse, with more than 30 years' experience in the NHS, higher education, voluntary and private sectors. Her most recent roles include as non-executive director at NHS Somerset Clinical Commissioning Group (CCG) where she was a Freedom to Speak Up Guardian.

3.7.2 NGO data

UHD continues to be an active contributor to the work from the NGO. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, census information and other surveys.

Quarterly information about speaking up cases are submitted to the NGO, outlining the themes and reporting the feedback received from those cases closed. Whilst number of referrals does not fully reflect the speaking up culture it does illustrate whether the FTSU is an established route for staff to use. Table 1, below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 1: NGO data **2021/22**	**Size**	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr 4**	**TOTAL** (qtr 1-3)
Dorset CCG	Small	1	2	0		**3**
Dorset County	Small	2	19	No data		**21**
Dorset Healthcare	Medium	24	31	28		**83**
Salisbury	Small	18	16	27		**61**
Solent	Medium	No data	2	7		**9**
University Hospitals Dorset	Medium	57	71	58	46	**186**
University Hospitals Southampton	Large	8	25	No data		**33**

Table 1 illustrates that the number of referrals coming to the FTSU team at UHD is above that of our neighbouring Trusts but also that of the national average for similar sized Trusts. The national average for medium/large trusts are 32.7 per quarter. UHD has just under double this with 58 cases per quarter. Speaking up needs to be everyone's business and not just our FTSU team.

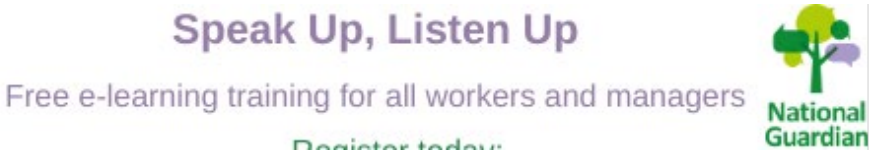
This is reflected further in the annual NGO FTSUG survey (section 3.7.5) which warned caution to our leaders with FTSUG carrying out more reactive work (listening to workers) rather than proactive (supporting the organisation to learn from the opportunities that speaking up brings and tackling the barriers). Speaking up will not become business as usual if FTSGU are spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place. This needs consideration and discussion. Many trusts are looking at developing deputy guardian roles to create resilience but also create more time for the FTSUG to help support the trust at being more proactive in the years coming.

The FTSU team wanted to look at why staff were using this route for concerns. Data has been collected since January this year (Qtr 4) by asking staff why they are using this route to raise concerns. Table 2 shows that in 52% of referrals, staff stated that their line manager was the issue of the concern. In 22% of the referrals the line manager was aware of the issue but not addressing the issue. The staff survey mirrors these observations (refer to section 3.7.6). Results show that for those whom completed it, whilst they felt issues and concerns would be addressed more than the average it is a decrease on results seen at UHD the year before (q17b). Furthermore, in Q21f, only 50.1% reported saying that they are confident issues would be addressed. The hypothesis that following the recent staff changes in management, staff were not aware of whom to escalate issues to is not playing out in this data.

Table 2: Why staff are using the FTSU team to raise concerns (Qtr 4, 2021/22)

	Qtr 4 (2021/22)
Unaware of who line manager is	3
Line manager is aware of the issue but have not acted or addressed the issue	10
Not secure in raising the concern with the line manager	2
The line manager is the issue of the concern	24
Did not think to ask my line manager	6
Unknown	1
TOTAL	**46**

3.7.3 NGO: Freedom to Speak Up training programme



'Speak Up, Listen Up, Follow Up', is an e-learning package, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

The National Guardian's Office, in association with Health Education England, has launched two modules. The first module '**Speak Up**' is core training for all workers including volunteers, students and those in training, regardless of their contract terms. Its aim is to help everyone working in health to understand what speaking up is, how to speak up and what to expect when they do. More recently, the second module;" **Listen Up**" is for managers at all levels, focuses on listening and understanding the barriers to speaking up.

The FTSUG has worked with our education team and the modules are now within our BEAT catalogue for staff to access and self-register. A communications strategy was launched to support this training in Summer 2021 and again during FTSU month.

There have been 222 people who has accessed the training, approximately 2% of the Trust. This is disappointing and needs further addressing and promotion. Conversations have occurred with our leadership training team as speaking up and creating psychologically safe space is essential toolkit for our line managers and leaders. Other Trusts have mandated this training and needs discussion and consideration.

The final "**Follow up**" module, for senior managers and leaders, was launched on 12th April. The package will provide an opportunity for leaders to pause and reflect on their influence in shaping the speaking up culture in UHD.

ACTION: Senior Leaders to commit to complete NGO/HEE the final module in the Freedom to Speak Up e-learning training package. You can self-enrol on BEAT in "Find eLearning" by typing Freedom to speak up. Leaders are advised to complete the first two modules before engaging with the final **Follow Up** module

3.7.4 NGO; Freedom to Speak up Strategy

The strategic direction of the NGO was published in July 2021 with contributions from national bodies, leaders and workers' representatives including outside the healthcare sector. It is based on the learning from the past four years following on from the introduction of the Freedom to Speak Up Guardian role, a key recommendation from the review by Sir Robert Francis after the events at Mid Staffs. The strategic framework is made up of four pillars of support: workers; FTSUG; leadership and the healthcare system. Under each pillar the framework outlines the focus of the work going forward.

The publication of this framework has allowed us to review and update our strategy going forward as UHD but also within an integrated care system. This strategy will be developed over the next few months and presented to the board for approval in the Summer.

3.7.5 NGO – Freedom to Speak up Guardian Survey (March 2022)

Each year the NGO undertake this FTSUG survey to gain an insight into the implementation of the FTSUG role and how this could be improved. This is the fifth survey of its kind and this year there was a response rate of 44.7%. Key findings are represented in Table 3 with comments and benchmarking of our own position at UHD.

The survey explicitly reminds us that leaders set the tone for fostering a healthy speak up, listen up and follow up culture. Unfortunately, whilst well documented, this is not the case for every Trust. Furthermore, the survey also concluded that other concerns needing addressing included understanding the role of the FTSUG more fully and being more effective role models for speaking up. At UHD, we have a well-established FTSUG with ring fenced time and access to the board. An action for us going forward is looking at the work the FTSU team is doing. Referrals continue to be higher than other similar sized trusts nationally resulting in the FTSUG carrying out more reactive work (listening to workers) rather than proactive (supporting the organisation to learn from the opportunities that speaking up brings and tackling the barriers). Speaking up will not become business as usual if FTSGU are spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place.

Table 3: Key findings of the **Freedom to Speak up Guardian Survey (March 2022)**	RAG rated	UHD comments
Speaking up Culture (see section 3.7.5)		
Almost 3 quarters of respondents (74.3%) thought that speaking up culture had improved over the last year.		Staff survey sub score; raising concerns is higher than average. Q17a – sign improvements from 2020 "feeling more secure in raising concerns
Sixty-three per cent of respondents said their organisation had a positive culture of speaking up, down 5% compared to 2020		Q21f is regarded to reflect a speaking up culture – 50.1% felt positive. No 2020 comparison
70.8% said that senior leaders supported workers to speak up. This is a 10% decrease on 2020.		Board support, development and annual declaration. Commit to complete NGO/HEE follow up e-learning
Respondents perceived that fear of retaliation as a result of speaking up (69%) and concerns that nothing will be done was a key barrier to speaking up (58.4%)		Q17b -less confident in addressing concerns as compared to 2020, but above average
75.3% said action was being taken to tackle barriers to speak up. 1 in 10 said action had not been taken		
72.1% agreed that detriment was taken seriously but 1 in 10 said that action taken was ineffective		Needs review and discussion with HR
Appointment and carrying out the role		
77.7% said they were appointed to FTSUG through fair and open competition		
60.4% had been in role for 18mths or longer		
FTSUG represented a wide range of occupational groups and pay bands		
72.1% were confident that they were meeting the needs of the workers		
45% of respondents said they spent most of their time on reactive elements of the role. Only 24.7% said they spent most of their time on the proactive aspects of the role		To pursue more time for proactive aspects of role. Line manager/leadership skills. ? deputy FTSUG role
81.3% of respondents report to their boards in person		
71.7% felt valued by managers they support.		
85.7% felt supported by CEO and senior leaders (77.9%)		
93.2% said they felt safe speaking up to senior leaders		
74.1% agreed with the statement "I feel confident that my suggestions and challenges to senior leaders will be acted upon		
81.9% said they had direct access to NED for speaking up		

83.1% said they had sufficient access to the board		
48.7% said they had sufficient time to carry out their FTSU duties		Time is spent of reactive rather than proactive aspects of role
29% said they had insufficient budget for expenses associated with the role.		
63.2% agree that they have access to rooms and space for private meetings		Space can be an issue for f2f and telephone appts.
Ring fenced time		
65.6% had ring fenced time to carry out their role		
Training for workers		
79.5% said speaking up training was available to workers		
Most respondents said this training was not mandatory		Uptake is 2% workforce. Improvement of uptake needed

Recommendations from FTSUG survey 2021	**ACTION for UHD in 2022/23**
Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from speaking up, tackling detriment and supporting further cooperation within organisations on all matters relating to speaking up	• FTSUG shares clear roles for key posts with board including expectations (as per NHSEI) • Review tackling detriment following speaking up (see below)
To improve their ability to act as effective role models for speaking up we encourage all leaders to complete the NGO/HEE "speak up, listen up and follow up training	• Completion of HEE/NGO e-learning Follow up training.
Senior leaders should discuss the findings of this survey with FTSUG and assess the amount of ring-fenced time and the balance of time available for reactive and proactive support for speaking up	• Completing as per this paper. • Review of provision to allow more proactive work.? Deputy case
There should be visible action on detriment for speaking up whenever this is reported	• Review on how this works practically. Work with HR and await final universal version of policy
Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback	• Board support for speaking up
AMBER ACTIONS for UHD (table 3 results)	
Review of space to have quiet f2f conversations	

Increase update of training for speaking up	More comms and integrate into leadership training programme/management modules
Increase Positive speaking up culture for all staff	FTSU campaign "speaking up is everyone's business"

3.7.6 NHS Staff Survey

This year's NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

1. We are Compassionate and inclusive
2. We are recognised and rewarded
3. **We each have a voice that counts**
4. We are safe and healthy
5. We are always learning
6. We work flexibly
7. We are a team

In support of this, the results of the NHS Staff Survey are now measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes new sub-scores, which feed into the People Promise elements.

Nearly 3,400 staff at University Hospitals Dorset responded to the staff survey which accounts for 37% of its total staff. Consequently, whilst slightly lower than previous years, this data remains an important set of information illustrating how are staff are feeling.

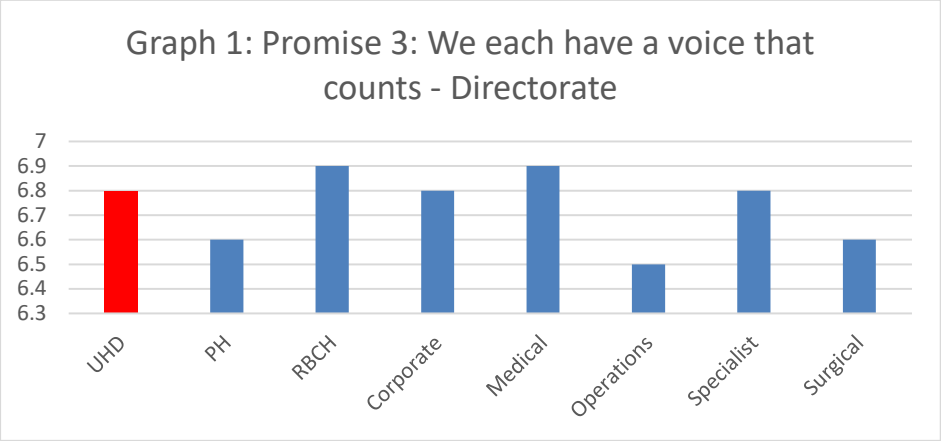
In previous years the staff survey asked 4 questions that made up the Freedom to Speak up Index Score which was used as a key metric for organisations to monitor the speaking up culture. This year, this is not the case and instead, speaking up culture is being measured within the People Promise Element "We each have a voice that counts". You will see there are 2 sub-scores within this element of which raising concerns is one of these. All of the scores are on a 0-10 scale, where a higher score is more positive than a lower score

Table 4: Staff Survey Results; We each have a voice that counts; Raising concerns

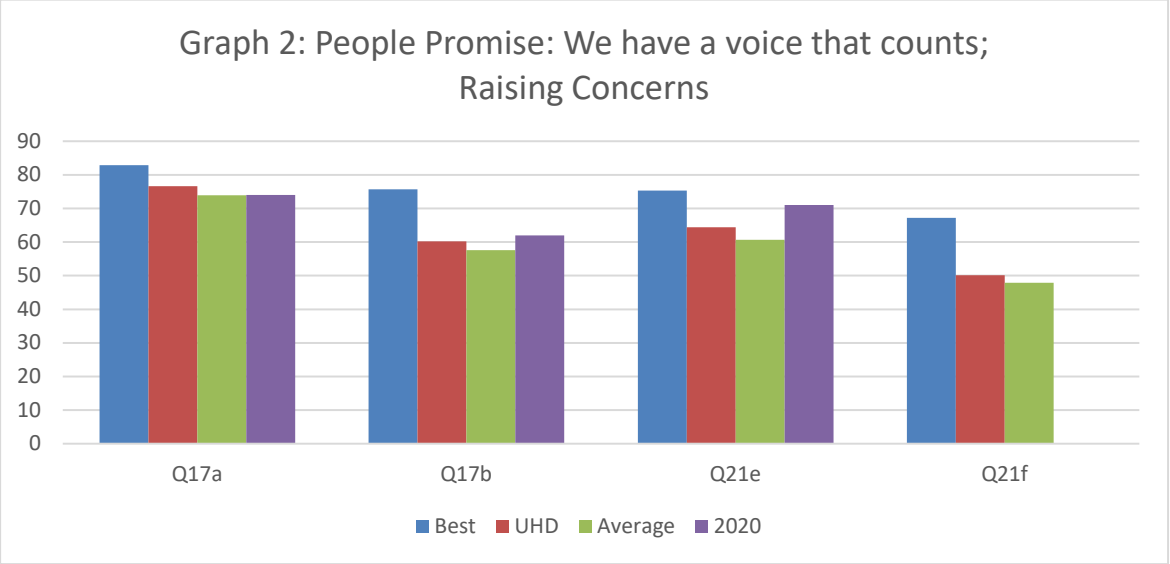
	We each have a voice that counts	Autonomy and control	Raising concerns
Best	7.3	7.3	7.3
UHD	6.8	7	6.6
Average	6.7	6.9	6.4
Worst	6.1	6.5	5.7

Table 4 illustrates that for those staff who completed the staff survey, responded above average when benchmarked against Acute and Acute & Community sector for both sub-scored questions, autonomy and control and raising concerns. Consequently, it can be concluded that for those whom completed the staff survey that staff feel they have a voice that counts as compared to an average.

Some of this data has been presented at directorate level and you will see in graph 1 some variations across UHD. You will notice that those staff based at the Poole site and within the Operations Care Group feel less like they have a voice that counts as compared to staff based at RBCH and within the medical care group. Once the heat maps are launched, we will be able to drill down into directorate and at times, department level.



To understand exactly which factors are driving the raising concerns sub-score, a number of questions feed into it and are represented in the graph below.



Q17a – I would feel secure raising concerns about clinical practice
Q17b – I am confident that my organisation would address my concern
Q21e – I feel safe to speak up about anything that concerns me in this organisation
Q21f – If I spoke up about something that concerned me, I am confident my organisation would address my concern.

In all questions that feed into the sub-score, raising concerns, UHD is higher than average when comparing to benchmarked Trusts. In Q17a, there is a significant improvement from 2020 with more staff "feeling secure about raising concerns about unsafe clinical practice".

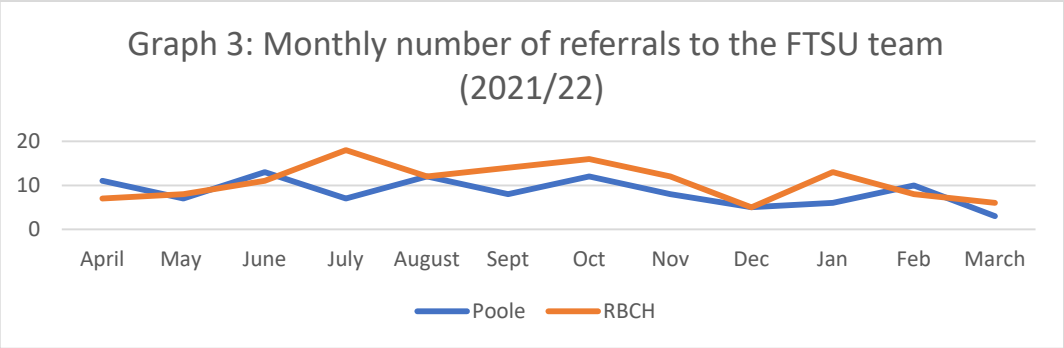
In contrast however, there have been reductions from 2020 in both Q17b (although not significant) and Q21e (significantly worse) reflecting in those staff who completed the staff survey, feeling less safe in raising concerns and less confident that they will be addressed.

Q21f is highly regarded to reflect a specking up culture and whilst this is the first year it has been asked, it shows only 50.1% of people whom completed the staff survey feel that if they were to speak up, that UHD would address it. This result, whilst disappointing, is higher than the average of 47.9%.

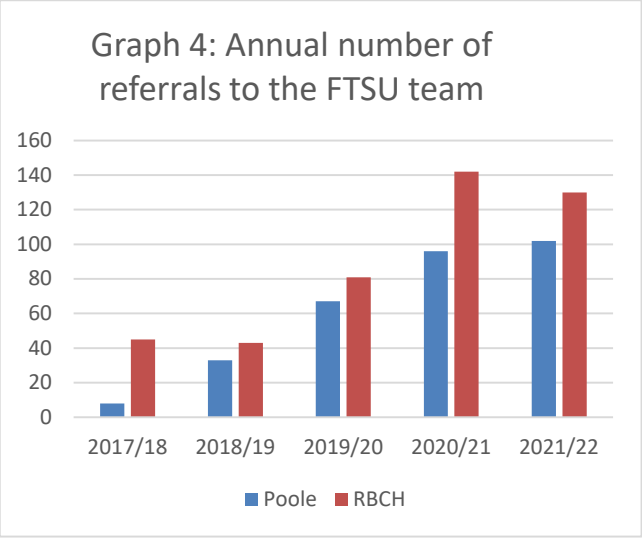
4.0 Case Referrals – the headlines

A range of data is collected by the FTSUG. This report will review the data including the key themes of concerns raised, where concerns have been raised and by whom. Referrals come from a number of routes including trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs, the UHD app and personal recommendation.

Graph 3 shows the number of referrals received on a monthly basis to the FTSU team over 2021/22. Referrals peaked in June at the Poole site and in July at RBCH. Activity in October increased on both sites reflecting the work being undertaken during the Speaking up month.

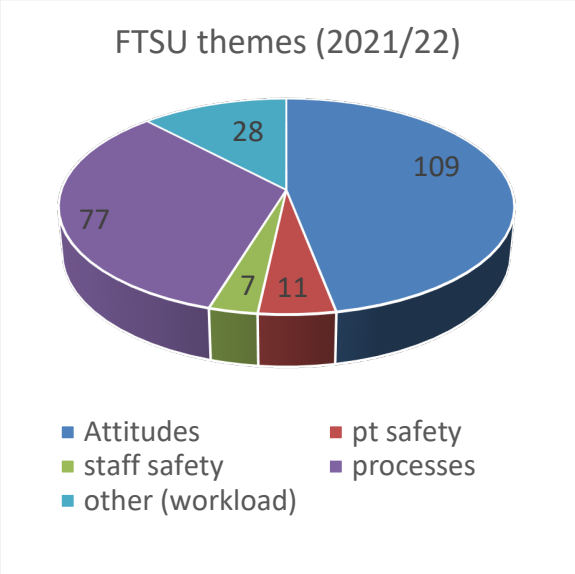


4.1 Key Themes of concerns



Graph 4 shows that the number of referrals to the FTSU team has maintained its activity to that seen in 2020/21 following a number of year on year increases. Forty-four per cent of referrals come from staff at our Poole site and 56% from RBH. Five per cent of referrals to the FTSU team were made anonymously which is an increase from last year (↑4%) but continues to be lower than that seen nationally (13%).

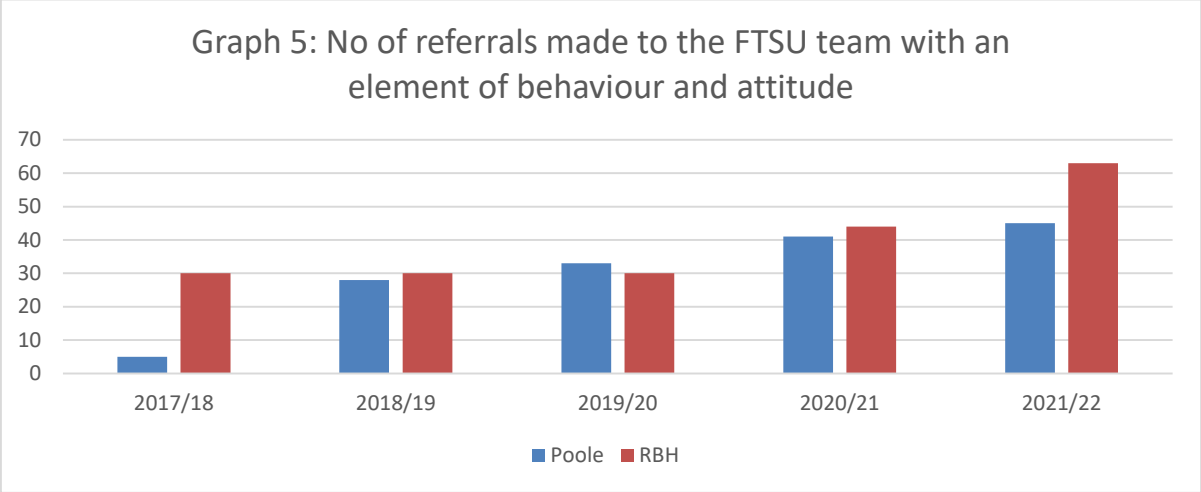
Staff approach the FTSU team for a number of reasons. The Pie Graph opposite illustrates the greatest theme had an element of attitudes and behaviours (47%). This is following by process and procedures (33%) and then workload and burnout (12%).



4.1.1 Behaviours and Attitudes (incivility)

Behaviours and attitudes continue to be the principle reason as to why people come to speak to the FTSU team. This year, fifty percent of cases at our Bournemouth site (63 staff), have an element of behaviour and attitude as compared to 44% at Poole (45 staff). This is a significant increase of cases at Bournemouth as compared to referrals in 2020/21 (increase of 43%; see graph 5 below).

These numbers increase even further in those staff from a BAME background. Seventy percent of referrals (23 staff) have an element of attitudes and behaviours and require the support of the FTSU team (refer to section 4.4).



This data can also be reflected in our recent staff survey. The NHS Staff Survey are now measured against the seven People Promise elements as outlined in section 3.7.6. The questions relating to respect and civility are within the People promise; we are compassionate and inclusive and the sub-score inclusion. Two new questions feed into this sub-score as outlined in table 5 but unfortunately do not yet have any trend data available:

Table 5: People Promise: We are compassionate and inclusive: sub-score inclusion		**Best**	**UHD**	**Average**
Q8b	The people I work with are understanding and kind to one another	**78.3%**	**71.6%**	**68.9%**
Q8c	The people I work with are polite and treat each-other with respect	**79%**	**73.4%**	**70.2%**

Table 5 illustrates that for those staff who have completed the staff survey, approximately one quarter feel that they are working in a culture which does not support civility or respect. The data is better when comparing that from our average benchmarking but some way from achieving that seen in the best organisations.

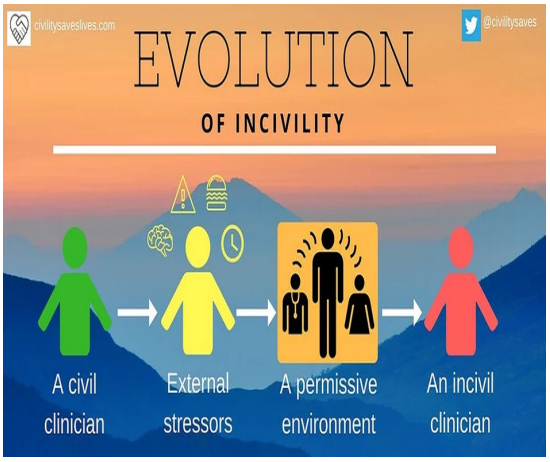
Other data that can be linked to behaviours and attitudes is the People Promise; We are safe and healthy and the sub-score negative experiences.

Table 6: People Promise: We are safe and healthy, negative experiences		Worst	UHD	Average	2020
Q13a	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	20.6%	13.9%	14%	14%
Q13b	In the last 12 months how many times have you personally experienced physical violence at work from managers?	2.2%	0.6%	0.6%	0
Q13c	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	4%	1.8%	1.6%	1%
Q14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	35.3%	27.3%	27.3%	25%
Q14b	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	17.9%	10.7%	11.9%	10%
Q14c	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	27.2%	20.9%	19.5%	18%

Table 6 shows how our staff who completed the staff survey feel as compared to a comparator average but also to those who completed the survey from UHD in 2020. You will notice that in 4 of the questions staff are feeling the same or better than the average in terms of physical violence and bullying and harassment. In 2 of the questions (Q13c and Q14c), questions referring to behaviours from our colleagues, are worse than the average but also a worsening position than that in 2020. This data mirrors what our staff are telling our FTSU and the behaviours of our behaviour to each-other, as colleagues (graph 5).

Research has shown that rude behaviour (incivility) within a clinical setting has a significant adverse impact on staff performance and patient health outcomes. With this in mind we need to become more conscious of how our internal world may be impacting our external world and take steps to care for ourselves and the people around us.

The Civility Saves Lives campaign also highlights that behaviours including disrespect and rudeness can also create an environment where quality of work reduces, people are less likely to help each-other and there are more errors as people are afraid to speak up. Patients also feel more anxious.



The way an organisation handles issues says a lot about the culture. At UHD, the intention is to support staff and to understand and change behaviour, not blame and punish. Stress negatively affects the way we act towards each other. When we feel scared or anxious we are more likely to lose our tempers, be rude and say or do things we normally wouldn't. Sometimes we may not even be aware that we are exhibiting these behaviours

The FTSU team in conjunction with HR, Occupational Health and our OD colleagues have pulled together some tools and support to help our own behaviours but also to address those whose behaviour is either dis-respectful and incivil https://intranet.uhd.nhs.uk/index.php/respect. Alongside this, HR have also commenced some exciting work and driving a Just and Learning Culture.

Steps to implement a just and learning culture involves creating an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. A restorative just culture asks: 'who are hurt, what do they need, and whose obligation is it to meet that need?' Establishing a just culture within an organisation requires action on three fronts:

1. building awareness,
2. implementing policies that support just culture, and
3. building just culture principles into the practices and processes of daily work.

Early data is showing that a number of formal concerns are being reviewed earlier and restorative alternatives being offered to support our colleagues in a more holistic and just way. This is the beginning of our journey and more needs to be done with those who have the gift to change.

4.1.2 Process and policy – compassionate and inclusive leadership

The next key theme to why staff approach the FTSU team is to do with process and policy. Thirty-three per cent of the issues raised include management processes such as appraisals, return to work support, rotas, feedback from interviews, supporting staff through merger, support during formal processes, sickness management and coding. A number of these issues often arise from a conversation or miscommunication with their line manager resulting in the FTSU team supporting the staff member, often providing re-assurance or clarification of the issues, and then encouraging them to speak again with their line manager. Indeed, when looking at why staff are coming to the FTSU team rather than their line manager, 52% of them stated that their line manager was the issue of the concern (table 2, section 3.7.2).

The gift of change lies predominantly with our line managers and clearly in most cases a resolution needs to happen with them. In other cases, it has been signposting them to the experts such as HR or our unions. Section 3.2 shows this.

It is well documented about the importance of delivering compassionate and inclusive leadership. It is encouraged that our leaders, and particularly our junior leaders, listen to our teams (with fascination), acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change. Indeed, Michael West outlines that to create cultures where staff feel cared for, needs our leaders to do 4 things, attend, seek information, empathise and help. Delivering compassionate leadership and care requires investment in time, in skill and an appreciation of the benefits for our people and ultimately the care we give to our patients. Compassion needs to meet people's needs for belonging and develop and sustain trust for psychological safety.

4.1.3 Safety – patient and staff

Eight per cent of referrals were related to quality and safety issues for either our staff or patients. Often these issues were escalated as they frequently needed addressing promptly (refer to section 4.3).

4.1.4 Other – burnout

Excessive workload affects patient safety, productivity and the health and wellbeing of staff. Burnout is a form of exhaustion caused by constantly feeling overwhelmed, emotionally drained and unable to keep up with demands. Michael West states that there an inverse relationship between compassion and burnout amongst healthcare professionals and until we address the triggers of burnout we will continue to have a workforce suspectable to burnout. At UHD 12% of staff who came to the FTSU team described excessive workload and signs of burnout.

4.1.5 COVID related themes

As compared to 2020/21 the number of referrals relating to COVID issues was dramatically lower (7% vs 39%). Most concerns relating to COVID this year were relating to guidance for staff and mainly vaccinations or isolation. All issues were referred to either HR and OH and resolved within hours of them being raised and in many cases were being already addressed.

4.2 Outcome of referrals

Table 7 illustrates the outcome of referrals once they were made to the FTSU team. Of those referrals, 34% of cases were escalated to the line manager to investigate and action. In 41% of cases, the member of staff was signposted to experts in the field of the concern such as HR, OH or other including infection control, risk and governance or our security experts. Eight per-cent of cases were escalated to director or executive level which is similar to that last year (10%). These issues would be deemed as needing senior leadership/direction or immediate action.

Table 7: Outcome of referrals received by FTSU team

2021/22		Poole	RBH	XCH	Total UHD
Line manager		45	31	2	**78**
FTSU advice		16	24		**40**
Escalate to Chief/Director		8	11		**19**
Signpost	HR	15	27	1	**43**
	OH	7	9		**16**
	Network	2	3		**5**
	Other	9	22		**31**
TOTAL		**102**	**127**	**3**	**232**

4.3 Who are raising concerns?

Table 8 shows that our shows nurses accounted for the biggest portion (34%) of speaking up cases raised with Freedom to Speak Up team, followed by our administrative staff (19%) and Allied Health Professionals (AHPs; 19%). Twelve staff felt necessary to remain anonymous, of which 10 of those where from RBH site. This figure remains lower than the national figure of 13% (refer to section4.1).

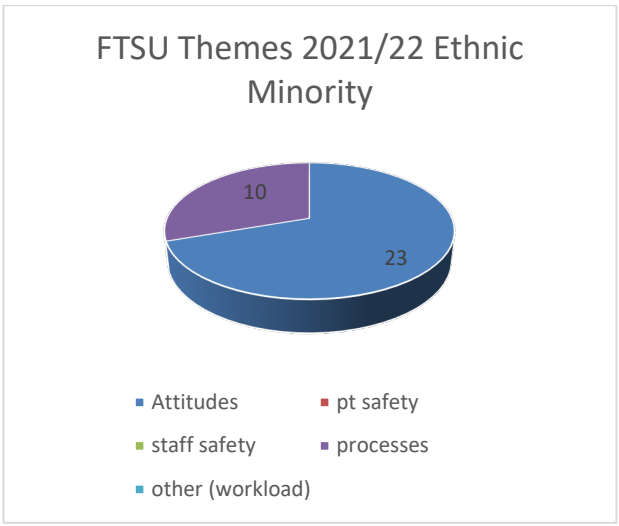
Special attention was made this year to engage with our medical workforce as it was noted that the number of referrals were down from the year before. This year the number of referrals has picked up again to 17 (7% of total referrals). The FTSU have increased the awareness of this route to escalating concerns by increasing the number of doctors on our FTSU team alongside our increased presence at junior doctor meetings, jointly presenting with our BMA team, presenting at our core induction and working with Chief Medical Officer, Guardian of working times and lead Medical Educator.

Table 8 : Staff who are raising concerns to the FTSU team

	Poole	RBH	XCH	Total UHD
AHP	23	21		**44**
Medical and Dental	7	10		**17**
Nursing/Midwife	37	41		**78**
Nursing assistant	9	8	2	**19**
Admin/clerical/maintenance ancillary	19	26	1	**45**
Corporate services	5	11		**16**
Anon	2	10		**12**
Other				
TOTAL	**102**	**127**	**3**	**232**
BAME	**10**	**22**	**1**	**33**

Another area of the workforce that needs focus is that within minority groups of the organisation. The Francis Freedom to Speak Up reviews highlighted that ethnic minority staff, including black and minority ethnic (BAME) workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews, also showed that minority staff groups are more likely to suffer detriment for having spoken up. The National Guardian Office (NGO) case reviews at Southport and Ormskirk Hospital NHS Trust highlighted the importance for every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.

Fourteen per cent of staff (33 staff) raised a concern from an ethnic minority background. All staff were signposted to our BAME networks who were also able to support and advise. The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee and will continue to work together to improve and support our ethnic minority employee experience.



When looking at the reason as to why our ethnic minority (BAME) staff raise referrals to our FTSU team, the proportion of referrals relating to attitudes and behaviours is significantly higher than compared to non-BAME staff. Seventy per cent (23 staff) report an element of behaviours as compared to 47% of all staff (109

Researchers have also established risk groups for bullying classified as having protected status. It has been found that the risk of bullying is more than double among ethnic or racial minorities compared to white respondents. Bullying and harassment at work has also been seen to be disproportionate within minority and protected groups. Where an individual is a member of more than one protected group, the probability of being bullied spirals (Roger Kline, 2020). Promoting equality and addressing health inequalities are at the heart of the NHS value and a key value at UHD.

Our staff survey show similar trends. The table below shows that in all 3 questions relating to bullying and harassment, staff from a BME background have a worse experience as compared to our white staff. In the questions relating to abuse from patients and staff, BME staff at UHD experience more harassment than the average.

Table 9	UHD		Average	
	White	BME	White	BME
Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months	26.3	30	26.5	28.8
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	23.9	31.1	23.6	28.5
Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months	7.4	16.8	6.7	17.3

3.4 Where are concerns being raised?

Significant effort has been made to ensure that the FTSU team visit and meet all members of staff across each site and the ambassador model allow for this. Table 10 outlines the concerns raised across our care group structure. The FTSUG monitors this closely so to ensure that all areas are aware of the FTSU service and how to access it.

Table 10: The number of concerns raised in UHD

2021/22					
Care Group	**Directorate**	**PHT**	**RBH**	**XCH**	**Total**
Medical (57)	Emergency and Urgent		6		**6**
	Acute and Ambulatory Medicine				
	Cardiology and Renal	2	5		**7**
	Medical specialities	7	20		**27**
	Older Persons and Neurosciences	11	6		**17**
Surgical (38)	Surgery		4		**4**
	Anaesthetics	7	5		**12**
	Head and Neck	4	8		**12**
	Trauma and Orthopaedics	7	2		**9**
	Private		1		**1**
Specialties (74)	Cancer Care	8	3	2	**13**
	Child Health	6			**6**
	Women's Health	11	1		**12**
	Radiology and Pharmacy	9	8		**17**
	Clinical Support	7	10		**17**
	Pathology	2	7		**9**
Operations (14)	Clinical Site				

	Facilities	5	8	1	**14**
	Partnership, integration and discharge				
	Emergency Planning				
	Operational Performance				
Corporate (37)		14	23		**37**
Anon (12)		2	10		**12**
TOTAL		**102**	**101**	**3**	**232**

4.0 Learning and reflections

Whilst each referral will have its own learning, themes can be drawn to help develop and embed our culture as a new organisation.

4.1 Compassionate and Inclusive leadership and People Management

It is well documented about the importance of delivering compassionate and inclusive leadership. It is encouraged that our leaders, and particularly our junior leaders, listen to our teams (with fascination), acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change. Indeed, Michael West outlines that to create cultures where staff feel cared for, needs our leaders to do 4 things, attend, seek information, empathise and help.

Our data from quarter 4 show that in over 50% of referrals made to the FTSU team came because the line manager is part of the concern. Often this is a miscommunication, poor message delivery or in 22% not acting or addressing the concerns.

Delivering compassionate leadership and care requires investment in time, in skill and an appreciation of the benefits for our people and ultimately the care we give to our patients.

4.2 Being Visible and Present

Another observation from those using the FTSU route, is the visibility/ presence of our leaders and carrying out a check in or healthy conversation. Being present, saying hello and building on the social capital goes a long way for our people. Common feedback is "my line manager has no time and does not appear to care". Investing time in our social capital is well researched and carries many benefits in building effective teams.

4.3 Developing a civil and respectful culture

Developing a civil and respective culture is another learning theme. Behaviours including disrespect and rudeness, can create an environment where quality of work reduces, people are less likely to help each-other and there are more errors as people are afraid to speak up. Patients also feel more anxious. Having the tools to feedback poor behaviours in a respectful and compassionate way is needed to ensure that issues are dealt in a quick and informal way with a mutual understanding. Early data is of the just culture in HR, is showing good results for those involved and more satisfactory outcomes are found. Clearly there are times we need to

escalate some behaviours to a more formal intervention. We now have our data from our staff survey and see that the gaps are how we are with each-other, fellow colleagues but also more emphasis and support for our BME colleagues.

4.4. Team integration

Another emerging theme has been the impact of 2 teams coming together and the anxiety that this is causing our staff. There are a number of reasons as to why teams coming together can find it difficult. These can include teams not knowing each-other, everyone thinking their way is best, hierarchical interests, lack of respect for each other, lack of clarity of objective and team role. Other factors can also be at play especially if a team is also moving location including transport, impact on home balance and uncertainty. An emerging theme has been that staff feel their voice and concern is not being heard or being dismissed without discussion. This has creating a number of staff to become so unsettled and undervalued. They have felt that if they had been listened to and adjustments made to implement this change, the levels of anxiety could have been avoided. Providing our line managers with the skills of holding these conversations and listening actively will be key going forward.

5.0 Summary and Next Steps

University Hospitals Dorset's values celebrates the importance of having an open and honest culture. Speaking up has never been as important as it is today. It is everyone's business to encourage speaking up. We are #TeamUHD and collectively we need to Speak Up, Listen Up and Follow Up so to continually improve our culture of safety.

University Hospitals Dorset
NHS Foundation Trust

APPENDIX A

Freedom to speak up:

Raising concerns

(whistleblowing) policy

If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version.

Out of date policy documents must not be relied upon.

Policy: Freedom to speak up: raising concerns (whistleblowing)
Version 3
January 2022

A) EXECUTIVE SUMMARY POINTS
This policy aims to improve the experience of whistleblowing at University Hospitals Dorset Foundation NHS Trust
This policy outlines why speaking up is important and gives examples of the concerns you can raise
This policy outlines the process on how staff raise concerns and how this can be done confidentially.
This policy describes the local escalation process for raising concerns
B) ASSOCIATED DOCUMENTS
• Civility, Respect and Dignity at Work Policy • Managing Grievances Policy • Managing disciplinary Policy • Managing Performance Policy • Fraud, bribery and corruption policy

C) DOCUMENT DETAILS	
Author:	Helen Martin
Job title:	Freedom to Speak Up Guardian (FTSUG)
Directorate:	Corporate
Version no:	3
Equality impact assessment date	7.9.20. Updated 1.2.22
Target audience:	All Trust employees including agency workers, temporary workers, students, volunteers and governors.
Approving committee / group:	Trust Board of Directors
Chairperson:	Chair of Board
Review Date:	September 2024

D) VERSION CONTROL

Date of Issue	Vers No.	Date of Review	Nature of Change	Approve Date	Approval Committee	Author
July 2019	1	July 2020	Adoption of NHSI/E policy with adapted local escalation	July 2019	Trust Board	Helen Martin
Sept 2020	2	Sept 2022	Merger to University Hospitals Dorset and amalgamation of policies with new	Sept 2020	Trust Board	Helen Martin

			local escalation. Refer to page 5,6 and appendices A and B for new email addresses and NED details Page 8: addition of CCG, Dorset as another contact outside the Trust			
Date of Issue	**Version No.**	**Date of Review**	**Nature of Change**	**Approve Date**	**Approval Committee**	**Author**
Jan 2022			**Section 2:** policy and purpose Additional clarification of the purpose of this policy and that consideration will be given to the most appropriate process and policy. A concern raised under this policy, and any ensuing investigation (section 11) will only take place if the concern raised falls within the legal definition of a public disclosure (whistleblowing; refer to section 3 for definitions **Section 3**: Addition definition: protected disclosure (whistleblowing) **Section 4**: additional guidance if there is a concern relating to suspicions of fraud. **Section 8** and **Appendix A**Replace name for CEO and our non-executive director (NED) with responsibility for whistleblowing (interim) Addition of escalating to Chair of Audit Committee if concern relating to financial misconduct. **Section 11** What we will do?Further clarification of what actions likely to take and signposting staff to existing policies. An investigation under FTSU will only occur if falls within the legal definition of a public disclosure **Appendix B** Addition of raising concern with Chair of Audit Committee if concern is relating to financial misconduct.	April 2022	Trust Board	Helen Martin

E) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
1/2	24th June 2019 3rd July 2019	Helen Martin	Workforce and OD Committee (WODC) Staff Partnership Forum (SPF)
3	20th Jan 2022 16th Feb 2022	Helen Martin	Audit Committee Workforce Strategic Committee (WSC)

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Appendix B - Diagram to highlight the process for raising and escalating concerns at UHD
Appendix C- A vision for raising concerns in NHS
Appendix D – Equality Impact Assessment

1. Introduction: Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

2. This policy and purpose

This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Our local processes have been integrated into this policy and provides more detail about how we will look into a concern at University Hospitals Dorset (UHD). Consideration will be given to the most appropriate process and policy for progressing your concern. This may be referring to existing suite of Employee Relations Policies which may be more relevant including but not limited to Civility, Respect and Dignity at Work, Managing Disciplinary Policy, Managing Grievances Policy and Managing Performance Policy. If the concern relates to financial misconduct, bribery and corruption this is better suited using our Fraud, bribery and corruption policy or by making a referral to our local counter fraud teams. Whilst concerns raised under this policy, an investigation within this policy (section 11) will only take place if the concern raised falls within the legal definition of a public disclosure (whistleblowing; refer to section 3 for definitions on page 5).

If you are unsure what route is best to take, you may like to discuss your concern with your line manager, Freedom to Speak up (FTSU) team, a HR colleague, your Trade Union representative or local Counter fraud team.

3. Definitions

The following definitions apply to this policy:

Freedom to speak up (FTSU)	A process encouraging staff to raise concerns and speak up to protect patients and improve the experience of NHS workers.

Freedom to Speak up Guardian (FTSUG)	A named person who acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation
Speaking up	Speaking up includes raising a concern, making a disclosure, offering a suggestion for improvement, whistleblowing, making a complaint. Speaking up when things go wrong, or things might go wrong. It can include when things are good but could be even better.
Protected Disclosure (Whistleblowing)	A qualifying disclosure which is made by a colleague and fulfils the requirement under the Public interest Disclosure Act (1998). To be covered by law, the colleague who makes a disclosure must reasonably believe 2 things. The first is that they are acting in the public interest. The second is that the disclosure tends to show past, present or likely future wrongdoing, falling into one or more of the following categories: • Criminal offence (including financial impropriety) • Failure to comply with an obligation set out in law • Miscarriages of justice • Endangering of someone's health and safety • Damage to the environment • Covering up wrongdoing in the above categories. Colleagues who make a protected disclosure are protected against dismissal and negative treatment in the grounds of having made a protected disclosure.

4. What concerns can I raise?

You can raise a concern about **risk, malpractice or wrongdoing** you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- ☐ unsafe patient care
- ☐ unsafe working conditions
- ☐ inadequate induction or training for staff
- ☐ lack of, or poor, response to a reported patient safety incident
- ☐ a bullying culture
- ☐ suspicions of fraud. This includes all concerns relating to financial misconduct, bribery and corruption. We encourage anyone that has reasonable suspicions of fraud to report them including all employees, patients, agents, trading partners, stakeholders and contractors.

Please refer to our Fraud, bribery and corruption policy on the intranet under non-clinical policy or you can also contact our local counter fraud team on:

Matt Wilson
Matt.wilson@rsmuk.com
07484 040691 Or

Heather Greenhowe
Heather.greenhowe@rsmuk.com
07800 617146

Or
Central NHS fraud and corruption hotline
Tel: 0800 028 4060 or Website: https://cfa.nhs.uk/reportfraud

For further examples, please refer to the video produced by Health Education England by clicking on the link below: **Health Education England video**

Remember that if you are a healthcare professional you may have a professional duty to report a concern. **If in doubt, please raise it.**

Don't wait for proof. We would like you to raise the matter while it is still a concern. It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled.

If you decide to raise a concern with the FTSU team, we will ensure full consideration will be given to the most appropriate process and policy for progressing your concern (refer to section 11). As in the cases of people with concerns about their employment that affect only them – that type of concern is better suited to our HR related policies and can be located on our Human Resources intranet site. Also, if your concern is relating

to financial misconduct, bribery and corruption this is better suited to be made via our local counter fraud teams.

5. Feel safe to raise your concern

If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

6. Confidentiality

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

7. Who can raise concerns?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

8. Roles and Responsibility: Who should I raise my concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor). But where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance.

If raising it with your line manager (or lead clinician or tutor) does not resolve matters[1] or you do not feel able to raise it with them, you can contact one of the following people:

1. Our Freedom to Speak up Guardian team who can be contacted on:

   - ☐ 0300 019 4220 or
   - ☐ freedomtospeakup@uhd.nhs.uk.

   The Freedom to Speak up Guardian (FTSUG) leads our team and is a role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation.

2. If you remain concerned after this, you can contact:

   - our executive director (CEO) with responsibility for whistleblowing:

     Siobhan Harrington 0300 019 4242 or Siobhan.Harrington@uhd.nhs.uk

   - our non-executive director (NED) with responsibility for whistleblowing (interim):

     Mr Pankaj Dave on Pankaj.Dave@uhd.nhs.uk

3. If your concern is relating to financial misconduct, bribery and corruption and you remain unhappy despite using the local counter fraud team you can contact:

   - our Chair of Audit Committee with responsibility for financial conduct:
     Mr Philip Green on Philip.Green@uhd.nhs.uk

4. If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 9.

[1] Appendix A/B sets out how our local process escalates a concern.

9. Advice and support

Support and advice is available in a number of places including human resources, occupational health and chaplaincy. However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

10. How should I raise my concern?

You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

11. What will we do?

We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns and will respond in line with them (see Appendix C).

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern you will receive an acknowledgement within two working days. A central record will be updated that records the date the concern was received, a summary of the concerns, where the concern was raised ie. Directorate and by profession. This record is only accessed by the FTSUG and will not be shared. The data will be anonymised for board and other governance purposes.

Consideration will be given to the most appropriate process and policy for progressing your concern. This may include, but not limited to:

- Taking direct action including supporting you to speak directly to your line manager or other appropriate manager or other relevant people including HR, Union reps, Occupational Health, Local Counter Fraud Officers, Risk and Governance and Organisational Development Team.
- Taking direct action and raising the concern on your behalf, liaising with other relevant people including HR, Union reps, Local Counter Fraud Officers, Organisational Development Team, Risk and Governance and Trust Chiefs/Non-Executive Directors
- Commissioning a review within the parameters of this or the most appropriate policy
- Commissioning a formal investigation within the parameters of the most appropriate policy

We will only undertake a review or investigation within this policy if your concern falls within the legal definition of a protected disclosure also known as whistleblowing (see section 3 for definition). All other concerns will be referred to the most UHD approved policy.

Investigation

If it is deemed appropriate to commission an investigation under this policy, we will ensure that there is someone suitably independent (usually from a different part of the organisation) and properly trained. The FTSUG themselves will not investigate your concern but will ensure an investigating officer is appointed to complete, record and report an investigation. The investigation will be objective and evidence-based and will produce a report that focuses on identifying and rectifying any issues and learning lessons to prevent problems recurring.

Any employment issues (that affect only you and not others) identified during the investigation will be considered separately and under the guidance of HR.

Communicating with you

We will always treat you with respect and thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share relevant information with you (while respecting the confidentiality of others).

How will we learn from your concern?

The focus of the action taken will be on improving the service we provide for patients and the working environment for our colleagues. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Board oversight

The board will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and wants you to feel free to speak up.

12. Monitoring and Review

We will review the effectiveness of this policy and local process at least every 2 years, with the outcome published and changes made as appropriate.

13. Raising your concern with an outside body

Alternatively, you can raise your concern outside the organisation with:

- ☐ NHS Improvement for concerns about:
  - ☐ how NHS trusts and foundation trusts are being run
  - ☐ other providers with an NHS provider licence
  - ☐ NHS procurement, choice and competition
  - ☐ the national tariff
- ☐ Care Quality Commission for quality and safety concerns
- ☐ NHS England for concerns about:
  - ☐ primary medical services (general practice)
  - ☐ primary dental services
  - ☐ primary ophthalmic services
  - ☐ local pharmaceutical services
- ☐ Health Education England for education and training in the NHS
- ☐ NHS Counter Fraud Authority for concerns about fraud and corruption.
- ☐ Clinical Commissioning Group, Dorset for concerns about quality and safety

14. Making a 'protected disclosure'

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it; refer to section 3 for definitions). There is also a defined list of 'prescribed persons', like the list of outside bodies above, to which you can make a protected disclosure. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

15. National Guardian Freedom to speak up

The new National Guardian can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.

Appendix A: Process for raising and escalating a concern at University Hospitals, Dorset

Step one

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

Step two

If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak Up team on:

- 0300 019 4220
- freedomtospeakup@uhd.nhs.uk

The FTSU team have been given special responsibility and training in dealing with whistleblowing concerns. They will:

- ☐ treat your concern confidentially unless otherwise agreed
- ☐ ensure you receive timely support to progress your concern
- ☐ escalate to the board any indications that you are being subjected to detriment for raising your concern via the FTSUG
- ☐ remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ☐ ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

Step three

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact:

- our executive director (CEO) with responsibility for whistleblowing:
  Siobhan Harrington 0300 019 4242 or Siobhan.Harrington@uhd.nhs.uk
- our non-executive director (NED) with responsibility for whistleblowing (interim):
  Mr Pankaj Dave on Pankaj.Dave@uhd.nhs.uk

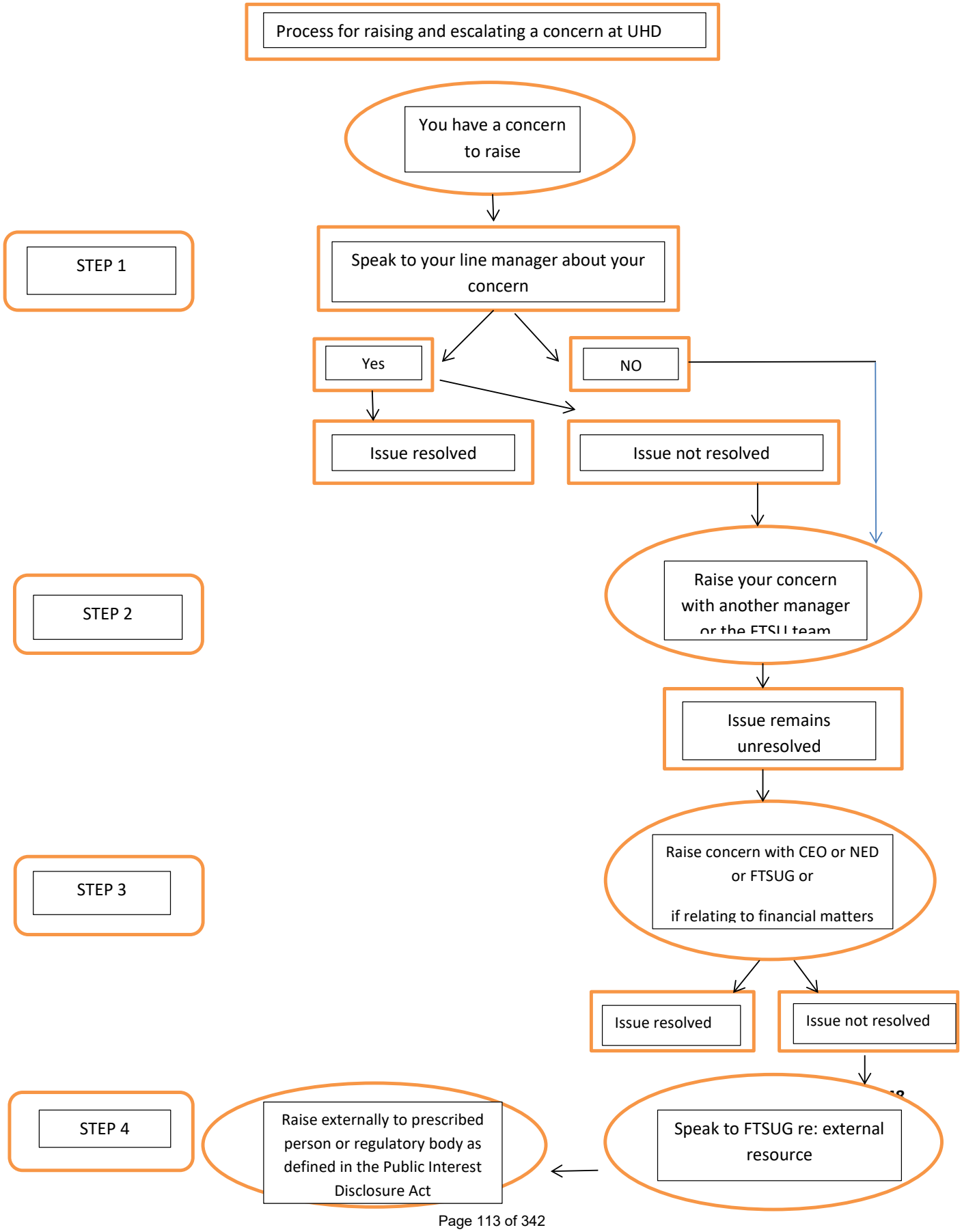
If your concern is relating to financial misconduct, bribery and corruption and you remain unhappy despite using the local counter fraud team you can contact:

- our Chair of Audit Committee with responsibility for financial conduct:
  Mr Philip Green on Philip.Green@uhd.nhs.uk

Step four

You can raise concerns formally with external bodies. Refer to page 9

Appendix B: Diagram to highlight the process for raising and escalating concerns at University Hospitals Dorset



Appendix C: A vision for raising concerns in the NHS

Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS*.

Policy: Freedom to speak up: raising concerns (whistleblowing)
Version 3
January 2022

This Policy has been produced by NHS Improvement with local adaptation.
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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

 Publication code: Policy 01/16
Publications Gateway Reference: 04877

Equality Impact Assessment

1. Title of document	**Freedom to speak up: Raising concerns (whistleblowing) policy**
2. Date of EIA	1.2.22
4. Directorate/Specialty	People Directorate, Organisational Development

5. Does the document/service affect one group less or more favorably than another on the basis of:

	Yes/No	Rationale
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	No	The policy applies to all staff working for the trust
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	No	The Trust will consider the impact making adjustments if the process deemed helpful e.g. meeting room for conversation. The policy can be in braille or larger print if needed
• Gender reassignment – the process of transitioning from one gender to another.	No	The policy applies to all staff working for the trust The SOP applies to all staff working for the trust
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	No	The policy applies to all staff working for the trust
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.	No	The policy applies to all staff working for the trust
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	No	The policy applies to all staff working for the trust The policy can be made available in an alternative language

• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	No	The policy applies to all staff working for the trust. When arranging conversations the team will be mindful of religious holidays/events.
• Sex – a man or a woman.	No	The policy applies to all staff working for the trust
• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	No	The policy applies to all staff working for the trust
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	
8. If the answers to any of the above questions is 'yes' then:		**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.	N/A	
Adjust the policy to remove disadvantage identified or better promote equality.	N/A	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.2

Subject:	Draft 2021/22 Code of Governance Comply or Explain
Prepared by:	Paula Shobbrook, Acting Chief Executive Pete Papworth, Chief Finance Officer Philip Green, Acting Chairman Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Paula Shobbrook, Acting Chief Executive

Purpose of paper:	To present for scrutiny the Board assessment assuring compliance or otherwise with NHS Improvement's (formerly Monitor) revised Code of Governance – July 2014.
Background:	The draft compliance report is scrutinised by the Audit Committee on an annual basis prior to presentation to the Board and ahead of the required explanations for the Trust's Annual Report.
Key points for members:	As part of the Trust's conditions as a Foundation Trust the Board of Directors is required to give explanation in the Annual Report for any non-compliance of NHS Improvement's (formerly Monitor) Code of Governance. The Trust is currently reporting for the period 2021/22. The Board's attention is drawn to sections A.5.12 and B.1.2.
Options and decisions required:	To review the assessment of compliance and approve the Code of Governance.
Recommendations:	The Board is asked to scrutinise the report and approve its assessment of compliance.
Next steps:	Elements of the comply or explain provisions summarized in the report will be incorporated into the Trust's Annual Report.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well-Led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	19 May 2022

UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

CODE OF GOVERNANCE COMPLY/EXPLAIN FOR 2021/22 ANNUAL REPORT

(*WORKING DOCUMENT for scrutiny to Audit Committee May 2022 & then to BoD for Approval May 2022)*

SECTION A: LEADERSHIP

A.1 The role of the board of directors

Main Principles		How Applied
A.1.a	Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation trust.	The directors believe that it is essential that the trust should be both led and controlled by an effective board of directors. The board of directors has adopted a formal statement of its powers, duties and responsibilities within the annual report.
A.1.b.	The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.	The board of directors collectively and each director individually will act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.

Supporting Principles		How Applied
A.1.c.	The role of the board of directors is to provide entrepreneurial leadership of the NHS foundation trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.	The board of directors provides entrepreneurial leadership and ensure that an effective system of internal processes, procedures and controls is in place at all times. Such a system shall be used to identify and manage risks that threaten the fulfilment of business objectives.
A.1.d.	The board of directors is responsible for ensuring compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.	The board of directors ensures compliance with statutory requirements and contractual obligations and its licence, its constitution and mandatory guidance issued by Monitor, now NHS Improvement (NHSI).

Supporting Principles		How Applied
A.1.e.	The board of directors should develop and articulate a clear "vision" for the trust. This should be a formally agreed statement of the organisation's purpose and intended outcomes which can be used as a basis for the organisation's overall strategy, planning and other decisions.	The board of directors has developed and articulated a clear vision for the trust. This agreed vision will be used as a basis for the organisation's overall strategy planning and other decisions.
A.1.f.	The board of directors should set the NHS foundation trust's strategic aims at least annually taking into consideration the views of the council of governors, ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.	Taking into consideration the council of governors' view through the full council, the board of directors shall agree business and strategic plans for the trust that shall be reviewed against performance and refreshed at least annually (see governance cycle) with a view to ensuring that the necessary financial and human resources are in place for the trust to meet its main priorities and objectives. The operational plan is shared with the council of governors The Board Assurance Framework (BAF) is reviewed by the Board on a six monthly basis. The board of directors shall evaluate critically on a regular basis its own performance. Both executive and non-executive directors undertake an annual appraisal.
A.1.g.	The board of directors as a whole is responsible for ensuring the quality and safety of health care services, education, training and research delivered by the NHS foundation trust and applying the principles and standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies.	The board of directors ensures the quality and safety of health care services, education, training, and research delivered by the trust and applies the principles of clinical governance set out by the Department of Health, the Care Quality Commission and NHSI's quality governance framework. There is a schedule of matters reserved for the board's decision.
A.1.h.	The board of directors should also ensure that the NHS foundation trust functions effectively, efficiently and economically.	The board of directors ensures the Trust operates effectively, efficiently and economically. Performance is overseen by the Finance and Performance Committee where regular reports on productivity and efficiency, operational performance and financial performance are considered.

Supporting Principles		How Applied
A.1.i.	The board of directors should set the NHS foundation trust's vision, values and standards of conduct and ensure that its obligations to its members are understood, clearly communicated and met.	The board of directors publishes the Trust's mission, vision, values and standards of conduct within its annual/operational plan, business and strategic plans and the annual report. The operational plan is shared with the council of governors at a public meeting and local stakeholders. Members and patients can access the Trust's vision, values and standards of conduct via the website.
A.1.j.	All directors must take decisions objectively in the best interests of the NHS foundation trust and avoid conflicts of interest.	Avoiding conflict of interests, directors shall take decisions objectively in the interests of the Trust.
A.1.k.	All members of the board of directors have joint responsibility for every decision of the board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the chief executive as the accounting officer.	Recognising the responsibilities of the CEO as the accounting officer the board of directors shall operate as a unitary board. The non-executive and executive directors share the same liability for board decisions.
A.1.l.	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.	The board of directors expects and receives constructive challenge from all of its directors and help to develop proposals on priorities, risk management, values, standards and strategy.

Supporting Principles		How Applied
A.1.m.	As part of their role as members of a unitary board, all directors have a duty to ensure appropriate challenge is made. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. Non-executive directors are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing and, where necessary, removing executive directors, and in succession planning.	The non-executive directors are aware of the duty to ensure challenge. The non-executives will also through receiving adequate information, monitor the reporting of performance (financial, clinical quality, governance and risk) ensuring mechanisms are robust and scrutinise the performance of the executive management in meeting the agreed goals and objectives. The board of directors has an Appointments and Remuneration Committee (Register D27) consisting of non-executive directors to determine the levels and remuneration of executive directors. The board convenes the committee for appointment/renewal and where necessary it would be convened for removal of executives on an ad-hoc basis.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.1.	The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors (as described in A.5). This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	YES	All in place: • Reservations and delegation of powers (Register D12) • Council of governors roles and responsibilities (Register E1) • Statement (dispute procedure) explaining how any disagreements between the council of governors and the board of directors will be resolved (Section 5 to Annex 6 of the Constitution). • Board responsibility/operating/decision statement (refer to annual report) • Statement board of directors/council of governors engagement policy October 2020 (Register D7) • Governance cycles (Register D17 & E12a)
A.1.2.	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent directors (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	YES	All details held within the annual report. (Register B2) Meetings and attendance registers for board and council. (Register B2 & D6)
A.1.3.	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	YES	The Trust has a statement which is included within the annual report.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.4.	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	YES	The Trust has the following reporting systems: • Trust Management Group • Board (BoD, Finance & Performance, Workforce Strategy, Quality, Audit, Private Patients Strategy, Charitable Funds, Transformation and Sustainability Committees) • Integrated Performance Report • ¼ Care Group Performance Reviews • Submissions to NHSI (or as required) • CQC
A.1.5.	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice for example from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	YES	Progress and delivery of key performance targets are assessed by monthly reporting against a range of metrics. If necessary the board would seek external independent advice to provide an adequate and reliable level of assurance. The annual internal audit work plan is developed taking into account key quality indicators and the Trust's risk register.
A.1.6.	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where, within the structure of the organisation, consideration of clinical governance matters occurs.	YES	The Trust has a Quality Committee that considers clinical governance and clinical improvement matters. The committee is chaired by a non-executive director and reports to the board of directors. The executive leads for clinical governance are the Chief Medical Officer and Chief Nursing Officer. The Trust has an operational Clinical Governance group chaired by the Chief Medical Officer and this group reports into the Quality Committee.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.7.	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	YES	The chief executive in post until 31 March 2022, as the accounting officer, has confirmed in writing to the chairman her understanding of the responsibilities as set out in the memorandum in a letter dated 15 December 2020.
A.1.8.	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (*The Nolan Principles*).	YES	The trust has a mission and vision and values statements for all staff. The values were developed using appreciative inquiry to listen to staff and patients in order to understand what they valued most. The board of directors subsequently approved the Values in October 2020. The board of directors approve and sign up to the trust's code of conduct which includes the Nolan principles. (Register D1). Directors are required to complete an annual fit and proper persons declaration.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.1.9.	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	YES	The board of directors approved and signed up to the Trust's code of conduct. (Register D1) The board of directors meetings are split into two sessions – the first being held in public. Agendas, minutes and supporting papers to the public part of the board meetings are available on the Trust's website. The agenda for the private meeting of the board meeting is also published on the website. Draft part 1 minutes of the board are shared with the council of governors when available and approved The chairman and chief executive provide a briefing to the governors on areas as appropriate from the private part 2 board of directors meetings.
A.1.10.	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	YES	The Trust holds liability insurance for the directors. It is not intended to extend this insurance to cover governors as it is felt that the risks of liability are very small.

A.2 Division of responsibilities

Main Principles		How Applied
A.2.a	There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the boards of directors and the council of governors, and the executive responsibility for the running of the NHS foundation trust's affairs. No one individual should have unfettered powers of decision.	The responsibilities are clearly defined within the constitution and powers of delegation. No one person has unfettered powers.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
A.2.1.	The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the board of directors.	YES	The chairman and chief executive's clear division of responsibility is set out in a public statement which is available on the Trust's website (Chairman vs Chief Executive Responsibilities Statement), supported by job descriptions.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.2.2.	The roles of chairperson and chief executive must not be undertaken by the same individual.	YES	The roles of chairman and chief executive are not undertaken by the same individual.

A.3 The chairperson

Main Principles		How Applied
A.3.a	The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.	The chairman shall lead the board of directors and the council of governors. The board of directors and council of governors shall be subject to performance review. The chairman shall invite contributions to setting the agendas for both the board and council.

Supporting Principles		How Applied
A.3.b.	The chairperson is responsible for leading on setting the agenda for the board of directors and the council of governors and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	The chairman sets the agenda for the board of directors and council of governors in line with the governance cycle and current business affairs of the Trust and adequate time is available for discussion of all agenda items, in particular strategic issues.
A.3.c.	The chairperson is responsible for ensuring that the board and council work together effectively.	The chairman ensures that the board and council work effectively through informal and formal communication routes.
A.3.d.	The chairperson is also responsible for ensuring that directors and governors receive accurate, timely and clear information which enables them to perform their duties effectively. The chairperson should take steps to ensure that governors have the skills and knowledge they require to undertake their role.	The chairman ensures that the agenda and papers for both parties are available in line with the requirements of the constitution. The chairman takes steps to ensure that governors have the skills and knowledge they require to undertake their role**.** This will include access to a comprehensive induction process and development training events.
A.3.e.	The chairperson should promote effective and open communication with patients, service users, members, staff, the public and other stakeholders.	The chairman promotes open and effective communications through the Trust's communication strategy which includes newsletters, briefings and reporting.

A.3.f.	The chairperson should also promote a culture of openness and debate by facilitating the effective contribution of non-executive directors, in particular and ensuring constructive relations between executive and non-executive directors.	The chairman promotes a culture of openness and debate by facilitating effective contribution and constructive and productive relations between executive and non–executive directors and board and council. There is a link between the non-executive director committee chairmen and the lead executive director for that committee. This arrangement means that non-executive directors and executive directors establish relationships based on appropriate advice, challenge and support. Governors are able to observe part 1 of the board and ask questions of the board of directors. They are also provided with a briefing after part 2 of the board meeting. Executives and non-executives shall be invited to attend the council of governor meetings.

	Code provision	Compliance Y/N	Evidence or Non Compliance Explanation
A.3.1	The chairperson should, on appointment by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	YES	Criteria met.

A.4 Non-executive directors

	Main Principles	How Applied
A.4.a	As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.	Non-executive directors are aware they should constructively challenge and help develop proposals on strategy. Non-executives will promote the functioning of a unitary board. The non-executive and executive directors share the same liability for board decisions. The board of directors expects constructive challenge from all of its directors and help to develop proposals on priorities, risk management, values, standards and strategy.

Supporting Principles		How Applied
A.4.b.	Non-executive directors should scrutinise the performance of management in meeting agreed goals and objectives, and monitor the reporting of performance. They should satisfy themselves on the integrity of financial information and that financial controls and systems of risk management are robust and defensible. They are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing executive directors, and in succession planning.	The non-executive directors are aware of the duty to ensure challenge. The non-executives will also through receiving adequate information, monitor the reporting of performance (financial, clinical quality, governance and risk) ensuring mechanisms are robust and scrutinise the performance of the executive management in meeting the agreed goals and objectives. The board of directors has an Appointments and Remuneration Committee (Register D27) consisting of non-executive directors to determine the levels and remuneration of executive directors and convenes a committee meeting for appointment/renewal and where necessary removal of executives on an ad-hoc basis**.** Succession planning was the subject of a Board Development session in September 2021 and will again be reviewed during 2022.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	YES	Senior independent director appointment is made in consultation with council of governors. Senior independent director's job description. (Register D24 and Constitution: Annex 7).
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate.	YES	The chairman meets with non-executive directors without executives present. The senior independent director meets with the non-executive directors without the chairman present to appraise the chairperson's performance. This is included in the performance processes agreed by the council of governors.
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	YES	All directors are aware of responsibilities and mechanisms. Details of concerns or actions are recorded in the board minutes.

A.5 Governors

	Main Principles	How Applied
A.5.a	The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.	The council of governors receives performance reports and scrutinises possible and actual breaches of the provider licence. Following elections to the Council of Governors for the new organisation, governors were invited to nominate themselves to observe the Board committees, to strengthen their duty to hold non-executive directors to account. The terms of reference of each committee includes the attendance of one governor in an observer role. Strategy and the priorities and objectives of the trust shall be the responsibility of the board of directors.
A.5.b.	The council of governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.	The Trust shall have a council of governors comprising (in the absence of any vacancies): • 17 elected • 5 appointed • 5 staff The governors shall be issued with and sign a code of conduct. (Register E2)
A.5.c.	Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.	Governors regularly feedback informally about the Trust and its vision and performance to members, the public and stakeholder organisations. The council of governors has a membership and engagement recruitment group that agrees a programme of events and engagement opportunities. Governors will also have their own column within the staff and member newsletter.

Supporting Principles		How Applied
A.5.d.	Governors should discuss and agree with the board of directors how they will undertake these and any other additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the local community and emerging best practice.	The council of governors shall agree its roles and responsibilities including additional roles. (Register E1)
A.5.e.	Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors must be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.	The council of governors are presented with, the annual report and accounts and annual plan at a general meeting. The council of governors are consulted on the development of forward plans and any significant changes to delivery of the Trust's business plan through the council of governors.
A.5.f.	Governors should use their voting rights (including those described in A.5.14 and A.5.15) to hold the non-executive directors individually and collectively to account and act in the best interest of patients, members and the public. If the council of governors does withhold consent for a major decision, it must justify its reasons to the chair and the other non-executive directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust. The council of governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.	The governors voting rights are set out in the constitution including partial reference to code provisions A.5.14 and A.5.15. Governors are aware of their roles and responsibilities reported in the Trust's constitution which is provided to governors at induction. The governors have to sign on appointment a register of interests, eligibility to vote declaration and a code of conduct which includes the Nolan principles.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.1.	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	YES	See Annex 5 of the constitution. The Council of Governors meeting schedule and governance cycle indicates meeting four times a year. Meetings are held early evening to accommodate the majority of governors.
A.5.2.	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the council of governors should be reviewed regularly as described in provision B.6.5.	YES	See Annex 3 of the constitution. The council has 27 members (in the absence of any vacancies) and the roles, structure and composition of the council are set out in the constitution which will be the subject of regular revision.
A.5.3.	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	YES	The annual report identifies members of the council of governors and the supporting details. Council record of attendance is maintained by the Company Secretary's Office: Committees and Governors (Register B5) and an annual register will be available on the website. The Trust has identified a new lead governor in March 2022.The role and responsibilities of the Lead Governor and Deputy Lead Governor have been agreed.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.4.	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	YES	The constitution includes roles and responsibilities of the council of governors and is available on the website. A membership strategy 2021-2024 has also been developed including a strategy for improving the quality of mutual engagement and communication so that members are well informed, motivated and engaged.
A.5.5.	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant director present at the meeting about the affairs of the NHS foundation trust.	YES	The chairman is responsible for leadership of both the board of directors and the council of governors. The council of governors' agenda, minutes and annual report for attendance demonstrates the attendance of the chief executive and relevant executive directors, at the council of governors meeting. The Senior Independent Director attends the council of governors' meetings.
A.5.6.	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the *new provider licence* or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	YES	See engagement policy and board and council dispute statement. (Register D7 and D7a) The Trust has appointed a senior independent director which is endorsed by the council of governors.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.7.	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	YES	There is a governance cycle for the Council of Governors. The agenda is set by the chairman of the council of governors in line with the constitution. Individual governors have the opportunity to pose questions to the board of directors and add items to the council agendas. Agendas, papers and other information are provided to the governors in a timely manner with, where possible, clear and unambiguous language.
A.5.8.	The council of governors should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	YES	See constitution clause 24. Board of directors and council of governors' engagement policy and dispute statement. (Register D7 and D7a)
A.5.9.	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example clinical statistical data and operational data.	YES	See council of governors' agenda, minutes and governance cycle. A performance report is presented to the governors at their meeting.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.10.	The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.	YES	The council of governors hold non-executive directors to account for performance of the board of directors through the performance reporting. The Governor's Nominations, Remuneration and Evaluation Committee (NREC) will receive the outcome of the chairman and non-executive director appraisals. The council also receives informally, reports from the non-executive director chairmen of board committees and a nominated governor for each board committee observes the meetings.
A.5.11.	The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the *NHS Foundation Trust Annual Reporting Manual*: (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report.	YES	The governors receive, once laid before parliament: (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.12.	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	NO	The governors are provided with an agenda before all Part 1 meetings of the board of directors and are provided with a copy of the approved minutes. Governors are provided with a briefing by the Chief Executive and/or Chairman on Part 2 matters with an opportunity for them to raise questions. The Trust considers that this provides the governors with more meaningful information than a redacted set of minutes may otherwise provide. This briefing is generally scheduled to take place on the day after the Part 2 meeting, providing the Governors with a more timely update than would otherwise occur through receiving minutes.
A.5.13.	The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust's or directors' performance.	YES	Directors accept the council of governors may require their attendance at a meeting of the council.
A.5.14.	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way.	Not applicable	The right to refer a question to the independent panel for advising governors is not used. NHS Improvement advised in January 2017 that the panel had been disbanded as no substantive questions had been put to the panel in over three years.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
A.5.15.	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These new voting powers require: • More than half of the members of the board of directors who vote and more than half of the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust. • More than half of governors who vote to approve a significant transaction. • More than half of all governors to approve an application by a trust for a merger, acquisition, separation or dissolution. • More than half of governors who vote, to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income. • Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions. NHS foundation trusts are permitted to decide themselves what constitutes a "significant transaction" and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.	YES	These new rights and voting powers from the 2012 Act are enshrined within the constitution.

SECTION B: EFFECTIVENESS

B.1 The composition of the board

Main Principles		How Applied
B.1.a.	The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.	The board of directors and its committees will have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively. From 1 January 2022, a NED vacancy existed. In addition, with a new Chief Executive joining the Trust (with effect from 1 June 2022) and a new Chairman joining, it was agreed that the Board of Directors would further review the skills and experience desirable for a replacement NED after the new Chairman had joined.

Supporting Principles		How Applied
B.1.b.	The board of directors should be of sufficient size that the requirements of the organisation can be met and that changes to the board's composition and that of its committees can be managed without undue disruption, and should not be so large as to be unwieldy.	The board comprises of the non-executive Chairman, 7 non-executive and 8 executive directors (in the absence of any vacancies).

Supporting Principles		How Applied
B.1.c.	The board of directors should include an appropriate combination of executive and non-executive directors (and in particular, independent non-executive directors) such that no individual or small group of individuals can dominate the board's decision taking.	The board of directors has an appropriate combination of executive and non-executive directors. Power and information shall not be concentrated in one or two individuals and there shall be strong presence on the board of directors of both executive and non-executive directors.
B.1.d.	All directors should be able to exercise one full vote, with the chairperson having a second or casting vote on occasions where voting is tied.	All directors are able to exercise one full vote, with the chairman having a second or casting vote on occasions where voting is tied. This is enshrined within the constitution.
B.1.e.	The value of ensuring that committee membership is refreshed and that undue reliance is not placed on particular individuals should be taken into account in deciding chairpersonship and the membership of committees. The value of appointing a non-executive director with a clinical background to the board of directors should be taken into account by the council of governors.	This shall be taken into account when deciding chairmanship and membership of committees. These entitlements shall be clear in the terms of reference of the board committees of: • Audit Committee; • Appointments and Remuneration committee; • Charitable Funds Committee; • Finance and Performance Committee; • Private Patients Strategy Committee; • Quality Committee; • Workforce Strategy Committee; • Transformation Committee; • Sustainability Committee. The council has appointed a non-executive director with clinical experience.

Supporting Principles		How Applied
B.1.f.	Only the committee chairperson and committee members are entitled to be present at meetings of the nominations, audit or remuneration committees, but others may attend by invitation of the particular committee.	The terms of reference for the nominations, audit and remuneration committees ensure only the committee chairman and committee members are entitled to be present at the meeting, but others may attend by invitation of the particular committee.

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
B.1.1.	The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director: • has been an employee of the NHS foundation trust within the last five years; • has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust; • has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme; • has close family ties with any of the NHS foundation trust's advisers, directors or senior employees; • holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; • has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or • is an appointed representative of the NHS foundation trust's university medical or dental school.	YES	Refer to annual report

Code Provisions		Compliance Y/N	Evidence or Non Compliance Explanation
B.1.2.	At least half the board of directors, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	NO	In the absence of any vacancies, the board comprises of 8 executive directors and 7 non-executive directors and a non-executive Chairman. The importance of ensuring a strong independent voice on the board of directors is supported by other provisions of the Trust's constitution and the standing orders of the board of directors including the non-executive Chairman having a casting vote and no resolution being passed if it is opposed by all the Non-Executive Directors present. From 1 January 2022, there were six non-executive directors excluding the chairperson, with a non-executive vacancy having arisen. Following the retirement of the Trust's chairman at the end of March 2022, it was agreed that the board of directors would further review the skills and experience desirable for a replacement non-executive director after the new chairman had joined. Please refer to B.1.a above.
B.1.3.	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	YES	No individual does.
B.1.4.	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	YES	The Annual Report and public statements will be published on the website following confirmation they have been laid before Parliament. (Register C1 & C2)

B.2 Appointments to the board

Main Principles		How Applied
B.2.a.	There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence.	The board of directors accepts that there should be a formal, rigorous and transparent procedure for the appointment of new directors. The Trust shall conform with legislation in appointing to the board of directors and on election of the council of governors. The council of governors has formalised and adopted terms of reference for a Nominations, Remuneration and Evaluations Committee.

Supporting Principles		How Applied
B.2.b	The search for candidates for the board of directors should be conducted, and appointments made, on merit, against objective criteria and with due regard for the benefits of diversity on the board and the requirements of the trust.	Board of directors appointments shall be made on merit based on objective criteria and terms of reference for the appointments committee and Nominations, Remuneration and Evaluations Committee.
B.2.c.	The board of directors and the council of governors should also satisfy themselves that plans are in place for orderly succession for appointments to the board, so as to maintain an appropriate balance of skills and experience within the NHS foundation trust and on the board.	The board of directors shall be satisfied through a regular board evaluation process. Please refer to B.1.a above.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.1.	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.	YES	See terms of reference for the appointments and remuneration committee and Nominations, Remuneration and Evaluations Committee. (Register D27 & E13) Please refer also to B.1.a above.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.2	Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations	YES	The "fit and proper" persons test is installed within the constitution. The Board approved a Fit and Proper Persons Policy in 2020 for the Trust. **For governors** A declaration is made on entering elections and taking up governorship. An annual declaration form is issued to governors. DBS checks for new governors are undertaken. **For directors (or equivalent)** Declaration made in signing contract of employment. Also evidenced by the signed end of year declaration form issued to all directors (or equivalent) – issued and held by the company secretary on behalf of the trust. DBS checks for new directors are undertaken and thereafter every three years.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.3.	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	YES	There are two committees: One for the appointment of chairman and non-executive directors: council of governors – nominations, remuneration and evaluation committee. (see ToR Register E13) One for the appointment of the executive directors: board of directors – Appointments and Remuneration Committee. (see ToR Register D27) Both committees for their respective appointments evaluate the balance of skills, knowledge and experience of the board in preparing to make appointments to the board of directors.
B.2.4.	The chairperson or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.	YES	See terms of reference for Nominations, Remuneration and Evaluations Committee and Appointments and Remuneration Committee (NREC). (Register E13 & D27) - for the appointment of non-executive directors the chairman chairs the NREC - for the appointment of a chairman an independent non-executive director chairs NREC.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.5.	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.	YES	See terms of reference for Nominations, Remuneration and Evaluations Committee and council of governors agendas and minutes. (Register E13) Process for the nomination of the chairman and non-executive directors has been agreed with the council of governors in March 2021.
B.2.6.	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	YES	See terms of reference for Nominations, Remuneration and Evaluations Committee. (Register E13)
B.2.7.	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	YES	See terms of reference for Nominations, Remuneration and Evaluations Committee. (Register E13)
B.2.8.	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive directors.	YES	The process followed will be described when required. (Register B7 & E13)
B.2.9.	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	YES	See terms of reference for Nominations, Remuneration and Evaluations Committee and appointments committee. (Register E13 & D26)

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.10.	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	YES	Statement within annual report An annual report of the Nominations, Remuneration and Evaluations Committee for the organisation shall be produced. (Register B8) The terms of reference of the committee are available on the website. The terms of reference of the appointments & remuneration committee are available on the website.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.11.	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	YES	Refer to constitution. Suitable candidates for executive director posts will be identified as part of the appointment process identified by the chairman and non-executive directors in the terms of reference of the Appointments and Remuneration Committee. (See C.1.2 below).
B.2.12.	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	YES	See clause 26 of the constitution and council of governors' agendas and minutes on the appointment of the chief executive.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.	YES	See terms of reference for Nominations, Remuneration and Evaluations Committee (Register E13) and council of governors' agendas and minutes. Process for the nomination of the chairman and non-executive directors has been agreed with the council of governors.

B.3 Commitment

Main Principles		How Applied
B.3.a	All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.	The directors' contract of employment or contract of service sets out the requirement that all directors allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.3.1.	For the appointment of a chairperson, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chairperson of an NHS foundation trust, should be the substantive chairperson of another NHS foundation trust.	YES	See terms of reference for Nominations, Remuneration and Evaluations Committee. (Register E13) See annual report for any disclosures in regards to the chairman's any other significant duties.
B.3.2.	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	YES	Terms and conditions available for inspection following request to the Company Secretary. Nominations, remunerations and evaluation committee lead the process to ensure non-executive directors undertake that they have sufficient time to meet other commitments and significant commitments are disclosed before appointment.
B.3.3.	The board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.	YES	Executive directors comply.

B.4. Development

Main Principles		How Applied
B.4.a.	All directors and governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and governors should make every effort to participate in training that is offered.	Directors and governors are required to complete a comprehensive induction process. Directors are subject to individual annual appraisal . Both directors and governors participate in training that is offered.

Supporting Principles		How Applied
B.4.b.	The chairperson should ensure that directors and governors continually update their skills, knowledge and familiarity with the NHS foundation trust and its obligations to fulfil their role both on the board, the council of governors and on committees. The NHS foundation trust should provide the necessary resources for developing and updating its directors' and governors' skills, knowledge and capabilities.	All directors and governors shall have access to the advice and services of the company secretary, who shall be responsible for ensuring the board and council procedures are followed, and to securing independent professional advice, if required, at the Trust's expense. The trust provides the necessary resources for developing and updating the board and council skills, knowledge and capabilities.
B.4.c.	To function effectively, all directors need appropriate knowledge of the NHS foundation trust and access to its operations and staff.	All directors are given a comprehensive induction to the Trust and have access to its operations and staff.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.4.1.	The chairperson should ensure that new directors and governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.	YES	Induction programme, including for new directors where practicable having regard to Infection Prevention Control, a hospital tour with the Chief Nursing Officer. (Register D2 & E3) Directors have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.
B.4.2.	The chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the board.	YES	The chairman shall meet with each director and agree training and development needs relating to their role on the board.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.4.3.	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	YES	The governors receive a comprehensive induction programme. The council has a development programme to support the governors' being equipped with the skills and knowledge to discharge their duties appropriately. Ad hoc training sessions are also arranged as required.

B.5 Information and support

Main Principles		How Applied
B.5.a.	The board of directors and the council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties. Statutory requirements on the provision of information from the board of directors to the council of governors are provided in *Your statutory duties: A reference guide for NHS foundation trust governors*.	The board of directors and council of governors shall be supplied in a timely manner with such information in a form and of a quality appropriate for them to discharge their respective duties. For the council of governors this includes the statutory requirements.

Supporting Principles		How Applied
B.5.b.	The chairperson is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and governors should seek clarification or detail where necessary.	The board shall receive a steady flow of information to enable it to discharge its duties, including a monthly report detailing current and forecast on financial and operations performance. Board papers shall be generally distributed not less than five days in advance of the relevant meeting to allow the directors fully to prepare for meetings. The board shall be kept fully informed of developments within the trust through regular seminar presentations by management. The council of governors shall receive a steady flow of information to enable it to discharge its duties, including reports detailing the overall current and forecast financial and operational performance. Council of governors' papers shall be generally distributed not less than five days in advance of the relevant meeting to allow the governors fully to prepare for meetings.

Supporting Principles		How Applied
B.5.c	The responsibilities of the chairperson include ensuring good information flows across the board, the council of governors and their committees, between directors and governors, and between senior management and non-executive directors, as well as facilitating appropriate induction and assisting with professional development as required.	The board shall receive regular updates on council of governors' views, via joint board and council development events and informal governor briefing attendance. All governors and directors receive an induction programme. Induction programmes for newly-appointed directors shall be devised to ensure that directors spend time with managers and visits to operational areas shall be included. Directors shall be subject to individual annual appraisals. The council of governors shall be subject to collective annual appraisals. There is an engagement policy in place for the board of directors and council of governors.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.5.1.	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	YES	The board and council are provided with agendas and supporting papers relevant to their need for knowledge and to the decisions they have to make. See the engagement policy, annual operational plan and annual report. The board has access to employees of the hospital as required to discharge their duties.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.5.2.	The board of directors, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	YES	The board of directors is aware of its obligations and commitments to the roles of executive or non-executive roles of the trust. The board will appoint where necessary relevant advisors where required. Information is supplied to the board of directors when requested: see board papers and minutes/action lists. Non-executive directors can and will utilise external assurance as required, particularly through the Audit Committee.
B.5.3.	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	YES	Independent advice available on request. The board has access to external sources of advice.
B.5.4.	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	YES	Support and resources in place for board of directors and council of governors. Budgets held by board and company secretary team.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.5.5.	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of an NHS foundation trust as they would in other similar roles.	YES	The non-executive directors receive agendas, papers and other correspondence in a timely and effective manner in line with the constitution. They are aware of their responsibilities to challenge recommendations or decisions of the board and utilise their full skills and experience. Non-executives can ask the board of directors for further information or reports that they consider useful.
B.5.6.	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	YES	The operational plan is reported to the finance and performance committee which includes governor attendance. The council of governors receives the operational plan in draft and subsequently final version. Executive directors and the Senior Independent Director are invited to attend the council of governors meetings, which are chaired by the Chairman. The annual report will contain a statement on how this requirement is undertaken.
B.5.7.	Where appropriate, the board of directors should take account of the views of the council of governors on the forward plan in a timely manner and communicate to the council of governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.	YES	The board of directors will consider and take account of the views of the council of governors on the NHS foundation trust's forward plan and communicate why they have or have not been incorporated.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.5.8.	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan.	YES	The forward plan of the Trust is discussed with the council of governors. The board of directors has regard for the views of the council of governors on the Trust forward plans through these mechanisms.

B.6. Evaluation

Main Principles		How Applied
B.6.a.	The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.	The board of directors shall undertake a formal and rigorous annual evaluation of its own performance and that of its committees and directors.
B.6.b.	The outcomes of the evaluation of the executive directors should be reported to the board of directors. The chief executive should take the lead on the evaluation of the executive directors.	The outcome shall be reported to the board of directors. The chief executive shall take the lead on the performance appraisal of the executive directors.
B.6.c.	The council of governors, which is responsible for the appointment and re-appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chairperson and the non-executives, with the chairperson and the non-executives. The outcomes of the evaluation of the non-executive directors should be agreed with them by the chairperson. The outcomes of the evaluation of the chairperson should be agreed by him or her with the senior independent director. The outcomes of the evaluation of the non-executive directors and the chairperson should be reported to the governors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chairperson.	The council of governors shall agree the process for the evaluation of the chairman and non-executives and the outcomes shall be reported to and agreed by the governors. The senior independent director shall lead the chairman's evaluation process.
B.6.d.	The council of governors should assess its own collective performance and its impact on the NHS foundation trust.	The council of governors shall assess its own collective performance and identify areas for development.

Supporting Principles		How Applied
B.6.e	Evaluation of the board of directors should consider the balance of skills, experience, independence and knowledge of the NHS foundation trust on the board, its diversity, including gender, how the board works together as a unit, and other factors relevant to its effectiveness. This should be reported to the council of governors with a specific focus on what changes are needed for improvement.	Regular evaluation of the board shall be undertaken and the council shall be made aware of the outcomes.
B.6.f.	Individual evaluation of directors should aim to show whether each director continues to contribute effectively and to demonstrate commitment and has the relevant skills for the role (including commitment of time for board and committee meetings and any other duties) going forwards.	The chairman shall act on the outcome of appraisals which identify individual and collective development needs for the board and non-executive directors. The chairman shall report to the council of governors on improvement needs of the non-executive directors. The chief executive will undertake the appraisal of the executive directors and report the outcomes to the Appointments and Remuneration Committee.
B.6.g.	The chairperson should act on the results of the performance evaluation by recognising the strengths and addressing the weaknesses of the board, identifying individual and collective development needs, and, where appropriate, proposing new members be appointed to the board or seeking the resignation of directors.	The chairman shall act on the outcome of appraisals, which identify individual and collective development needs and where necessary will propose new members be appointed to the board of directors or seek the resignation of directors.
B.6.h.	The focus of the chairperson's appraisal will be his/her performance as leader of the board of directors and the council of governors. The appraisal should carefully consider that performance against pre-defined objectives that support the design and delivery of the NHS foundation trust's priorities and strategy described in its forward plan.	The chairman shall have an annual appraisal based on his performance as leader of the board of directors and council of governors. The appraisal shall be based on the pre-defined objectives of the previous year's outcomes and in line with the trust's strategic priorities and objectives within the annual operational plan.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.6.1.	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.	YES	The annual report will refer to the process of performance evaluation. The board will use external assessors on a regular basis. A statement shall be made within the annual report.
B.6.2.	Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	YES	The evaluation of the board will be externally facilitated at least every three years.
B.6.3.	The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors.	YES	The senior independent director leads the performance evaluation of the chairman, within a framework agreed by the council of governors and taking into account the views of directors and governors.
B.6.4.	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	YES	There is an agreed performance review process (Register D4a). The outcomes of the evaluation are the basis of development programmes for the future.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.6.5.	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors. • communicating with their member constituencies and the public and transmitting their views to the board of directors; and • contributing to the development of forward plans of NHS foundation trusts. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Monitor's publication: *Your statutory duties: A reference guide for NHS foundation trust governors*.	YES	A review of the council of governor's collective performance shall be undertaken and the outcomes reported in the public part of a Council of Governors meeting.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.6.6.	There should be a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	YES	The trust has a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This has been shared with governors. The process also provides for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. The Trust has provision within its constitution and its code of conduct for governors that provides for requesting an independent assessor where there is a disagreement as to whether the proposal to remove a governor is justified.

B.7 Re-appointment of directors and re-election of governors

Main Principles		How Applied
B.7.a.	All non-executive directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The performance of executive directors of the board should be subject to regular appraisal and review. The council of governors should ensure planned and progressive refreshing of the non-executive directors.	The re-appointment of non-executive directors shall be determined by the constitution noting NHSI's code of governance. Governors shall have three year or two year tenure at the end of which their seats will be up for election. Governors can stand for a maximum of nine years at the trust.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.7.1.	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g., two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.	YES	Non-executive directors and the chairman are nominated by the Nominations, Remuneration and Evaluations Committee for reappointment by the council of governors in line with the code of governance. The chairman reports to the Nominations, Remuneration and Evaluations Committee and council of governors on the performance evaluation of the non-executive directors considered for reappointment. See terms of reference for the Nominations, Remuneration and Evaluations Committee. (Register E13) There shall be a rigorous review of non-executive directors who exceed six years in their role including that of their independence. This is not applicable at the present time, given the new organisation.
B.7.2.	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	YES	See model rules of election within the constitution. NOTE The Trust's model rules of election do not include the requirement to place the number of meetings each governor has attended and other such events. However the Trust shall publish this information in the annual report.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
B.7.3	Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors.	YES	See Terms of Reference for Nominations, Remuneration and Evaluations Committee. (Register E13) Re-appointments of non-executive directors shall take place through the Nominations, Remuneration and Evaluations Committee and council of governors. All other executive director posts are appointed through the Appointments and Remuneration Committee. (Register D27)
B.7.4	Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	YES	Non-executive directors and chairman are nominated by Nominations, Remuneration and Evaluations Committee for appointment by the council of governors in line with the code of governance. The chairman reports to the Nominations, Remuneration and Evaluations Committee and council of governors on the performance evaluation of the non-executive directors. See terms of reference for Nominations, Remuneration and Evaluations Committee. (Register E13)
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	YES	Refer to model rules of election within the constitution. Refer to register of governors.

B.8 Resignation of directors

Main Principles		How Applied
B.8.a.	The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate succession planning.	The board of directors retain the necessary skills to ensure on-going compliance with the NHS foundation trust with its licence, its constitution, mandatory guidance issued by NHSI, relevant statutory requirements and contractual obligations. The board through the chairman and senior independent director shall work with the council of governors to ensure appropriate succession planning for non-executive directors. The composition of the board is reviewed when a new post is required to be filled.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
B.8.1.	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	YES	The Appointments and Remuneration Committee will not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment. See Appointments and Remuneration Committee terms of reference. (Register D27) See nominations, remuneration and evaluation committee terms of reference (CEO position only). (Register E13)

SECTION C. ACCOUNTABILITY

C.1 Financial, quality and operational reporting

Main Principles		How Applied
C.1.a.	The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.	The board of directors will present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.

Supporting Principles		How Applied
C.1.b.	The responsibility of the board of directors to present a fair, balanced and understandable assessment extends to all public statements and reports to regulators and inspectors, as well as information required to be presented by statutory requirements.	The Trust's communications team is developing a communications and engagement strategy. The board of directors shall endorse this and the emerging closer working relationship with the communication and engagement teams in the Our Dorset Integrated Care System through our own communications team as we seek to implement the Clinical Services Review. Our communications team also works closely with NHS England and Improvement regional and national communications teams on public statements and media engagement. This allows us to build on what works best taking the best practices forward. This includes setting out four enabling factors for successful engagement: a strong strategic narrative, engaging managers, nurturing the employee voice and organisational integrity.
C.1.c.	The board of directors should establish arrangements that will enable it to ensure that the information presented is fair, balanced and understandable.	External communication activities are overseen by the Associate Director of Communications. Public messages such as media statements are approved as appropriate by an executive director in line with the trust's media policy. Our external website can be tailored by users to ensure it is easily accessible by all.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.1.1.	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	YES	See relevant annual report sections: • board of director's responsibilities • statement from external auditors • annual governance statement
C.1.2.	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	YES	Refer to annual report, audit committee agenda and finance and performance committee agenda.
C.1.3.	At least annually and in a timely manner, the board of directors should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance. Further requirements are included in the *NHS Foundation Trust Annual Reporting Manual.*	YES	Refer to the trust's operational plan Refer to annual report (from the chief executive supported by the Chief Finance Officer).

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.1.4.	a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.	YES YES	Board of directors aware of duty. Board of directors aware of duty.

C.2 Risk management and internal control

Main Principles		How Applied
C.2.a.	The board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.	The board of directors has a risk management structure. The board assurance framework is produced with links to the strategic objectives. The board receives regular updates on the trust risk register. All new red risks are reported to the Board of directors and the strategic risks faced by the trust are considered at every board meeting. The Risk Management Strategy approved by the board in 2020 contains the risk appetite of the board. The strategy supports delivery of the Trust's corporate objectives and describes the organisation's approach to the identification, assessment and management of risk.
C.2.b.	The board of directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHS foundation trust's assets, and service quality. The board should report on internal control through the Annual Governance Statement (formerly the Statement on Internal Control) in the annual report.	The board of directors shall maintain a sound system of internal control. The processes are considered by the audit committee and approved by the board of directors and are published as part of the annual report.

Supporting Principles		How Applied
C.2.c.	An internal audit function can assist a trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluating and continually improving the effectiveness of its risk management and internal control processes.	The externally sourced internal audit function assists the trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluating and continually improving the effectiveness of its risk management and internal control processes.
C.2.d.	If a trust has an internal audit function, the head of that function should have a direct reporting line to the board or to the audit committee to bring the requisite degree of independence and objectivity to the role.	N/A The internal audit is externally sourced with reports to the Audit Committee.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.2.1.	The board of directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	YES	The Trust through its Audit Committee maintains continuous oversight that its risk management and control systems are subject to regular independent audit. The Trust provides the relevant confirmation in its annual report.
C.2.2.	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	YES	The trust does have an internal audit function and appropriate details are provided in the annual report by the Chief Finance Officer.

C.3 Audit committee and auditors

	Main Principles	How Applied
C.3.a.	The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors. Monitor's publications, *Audit Code for NHS Foundation Trusts* and *Your statutory duties: A reference guide for NHS foundation trust governors*, provide further guidance.	The board of directors has appointed an Audit Committee to ensure compliance with corporate reporting, risk management and internal control principles. Following an agreed tendering process the council of governors, approved the appointment of KPMG in October 2017 as the external auditors for a three year period. Nominated governors were fully involved in the selection process at all stages. The Committee reviews the performance of auditors on an annual basis. The key elements include a review of performance in relation to the contracted service specification, the standard of audits conducted, the recording of any adjustments, the timeliness of reporting, the availability of the Auditor for discussion and meetings on key issues, and the quality of reporting to the Audit Committee, the board of directors and the council of governors. The committee has agreed a policy for the use of external auditors for non-audit work and would directly approve such work. The Audit Committee ensures full compliance with the NHS Code for NHS Foundation Trusts.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.1.	The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively; including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.	YES	Four independent non-executive directors (excluding the chairman) are members of the Audit Committee. One member of the committee has recent and relevant financial experience. The Audit Committee shall produce an annual report of its work. (For the period from 1 April 2022 to 30 June 2022 – outside of the period under this report - the Chair of the Audit Committee and Vice Chairman of the Trust also held the position of Acting Chairman of the Trust following agreement by the Board of Directors that this was in the best interests of the Trust in the particular circumstances (including, but not limited to, the limited timeframe) and pending the new Chairman of the Trust being in post).

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.2.	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly. It should include details of how it will: • Monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them; • Review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; • Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements; • Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; • Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and • Report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.	YES	See Audit Committee terms of reference which are published on the website. (Register B15) A policy statement on external audit providing non-audit services was endorsed by the Shadow Interim Board of Directors in June 2020. The policy will be reviewed in 2023. An annual report of the Audit Committee shall be submitted to council of governors including the terms of reference for review. Ad-hoc issues would be reported to the council as required. The chairman of the Audit Committee provides an update to governors on an annual basis.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.3.	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.	YES	Following agreement across all five Dorset health bodies, a procurement exercise was undertaken for the provision of external audit services. (Register D16 The appointment of external auditors, KMPG for an initial three year period from April 2018). The Chief Finance Officer is satisfied with the effectiveness of the external audit process and provides council with details of how the Trust monitors their performance from input from Trust staff that have regular contact with the auditors.
C.3.4.	The audit committee should make a report to the council of governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the council of governors to consider whether or not to re-appoint them. The audit committee should also make recommendation to the council of governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.	YES	Appointment of the auditors has been made. Performance shall be evaluated at the same time as remuneration is reviewed, as part of the annual review of performance.
C.3.5.	If the council of governors does not accept the audit committee's recommendation, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	YES	Would do so in the event.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.6.	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.	YES	The council agreed a tendering process for the appointment of external auditors from April 2018 and approved the appointment of KPMG as the external auditors for a three year period, in October 2017, with options to extend, which have been exercised.
C.3.7.	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	N/A	Would do so in the event.
C.3.8.	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	YES	The Audit Committee will review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in matters of financial report and control, fraud, bribery and corruption, clinical quality, patient safety or other matters as per its terms of reference and governance cycle. The job description for the freedom to speak up guardian is based on the guidelines provided by the National Guardian's Office. The Freedom to Speak Up Guardian presents a bi-annual report to the Board.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
C.3.9.	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	YES	The annual report contains a description of the work of the Audit Committee in discharging its responsibilities.

SECTION D: REMUNERATION

D.1 The level and components of remuneration

Main Principles		How Applied
D.1.a.	Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead the NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.	The Trust shall look to work within benchmarking parameters when setting levels of remuneration. The Appointments and Remuneration Committee shall review the VSM guidance annually/when published.

Supporting Principles		How Applied
D.1.b.	Any performance-related elements of executive directors' remuneration should be stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any competencies required and specified within the job description for the post.	N/A
D.1.c.	The remuneration committee should decide if a proportion of executive director's remuneration should be structured so as to link reward to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration levels with no corresponding improvement in performance.	The Appointments and Remuneration Committee has decided not to link remuneration to corporate and individual performance but will keep this decision under review.
D.1.d.	The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS foundation trust, especially when determining annual salary increases.	The Appointments and Remuneration committee shall be aware of employment conditions elsewhere in the trust when determining annual salary increases.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
D.1.1.	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: i) The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	YES	Performance related pay eligibility considered and decided it will not apply within the Trust however this will be kept under review.
D.1.2.	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	YES	Levels of remuneration for the chairman and non-executive directors are approved by the council of governors and reflect time commitments and responsibilities.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
D.1.3.	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	YES	Currently N/A. Refer to the Appointments and Remuneration Committee terms of reference.
D.1.4.	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	YES	Refer to Appointments and Remuneration Committee terms of reference and trust recruitment processes.

D.2 Procedure

Main Principles		How Applied
D.2.a.	There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.	The Appointments and Remuneration Committee shall comprise of non-executive directors and will consider executive remuneration. The outcome of which shall be published in the annual report.

Supporting Principles		How Applied
D.2.b.	The remuneration committee should consult the chairperson and/or chief executive about its proposals relating to the remuneration of other executive directors.	The Appointments and Remuneration Committee shall consult with the chief executive on remuneration proposals for other directors.

D.2.c.	The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.	The Appointments and Remuneration Committee may appoint independent consultants.
D.2.d.	Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.	The Appointments and Remuneration Committee shall observe this duty of care.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
D.2.1.	The board of directors should establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	YES	Refer to Trust Appointments and Remuneration Committee terms of reference. Membership of the committee is all non-executive directors and the trust chairman. Remuneration consultants were instructed to provide an opinion on the remuneration of the Executive Directors of the new Foundation Trust.
D.2.2.	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	YES	The Appointments and Remuneration Committee has determined that the definition of 'senior management' should be limited to board members only. All other staff remuneration is covered by the NHS Agenda for Change pay structure.

D.2.3.	The council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	YES	See council of governors/Nominations, Remuneration and Evaluations Committee papers. The remuneration of the chairman was considered with external advice ahead of the forthcoming chairman's appointment in July 2022. External advice will be sought when making material change to the remuneration.

Relevant statutory requirements		**Compliance Y/N**	**Evidence or Non Compliance Explanation**
D.2.4.	The council of governors is responsible for setting the remuneration of nonexecutive directors and the chairperson.	YES	The council of governors approve the remuneration of the chairman and non-executive directors on an annual basis.

SECTION E. RELATIONS WITH STAKEHOLDERS

E.1 Dialogue with members, patients and the local community

Main Principles		How Applied
E.1.a.	The board of directors should appropriately consult and involve members, patients and the local community.	The board of directors shall appropriately consult as required.
E.1.b.	The council of governors must represent the interests of trust members and the public.	The council of governors represent the interests of trust members and the public.
E.1.c.	Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.	The board of directors as a whole will take responsibility to ensure that regular and open dialogue with its stakeholders takes place.

Supporting Principles		How Applied
E.1.d.	The board of directors should keep in touch with the opinion of members, patients and the local community in whatever ways are most practical and efficient. There must be a members' meeting at least annually.	The Trust's board of directors meeting starts with a patient story to support the voices of patients are heard. The council of governors has a membership and engagement group and part of their work is to hold events to gather public opinion, including at our Trust open day. This engagement will be developed by the group. The communications team share media headlines with the board of directors to ensure they are kept in touch with public opinion and highlight anything that they board of directors needs to be aware of. There is a members' meeting held annually.

Supporting Principles		How Applied
E.1.e.	The chairperson (and the senior independent director and other directors as appropriate) should maintain regular contact with governors to understand their issues and concerns.	The board of directors through formal and informal routes maintains sufficient contact with governors to understand their issues and concerns.
E.1.f.	NHS foundation trusts should use an open annual meeting and open board meetings, both of which trusts are required to hold, to encourage stakeholder engagement.	The trust uses the annual members (open) meeting and open board meetings to encourage stakeholder engagement.
E.1.g.	Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public regarding the trust, its vision, performance and material strategic proposals made by the trust board.	Governors seek the views of members and the public on material issues or changes being discussed by the trust. Governors provide information and feedback to members and the public regarding the trust, its vision, performance and material strategic proposals made by the trust board.
E.1.h.	It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that will enable them to fulfil their duty to represent the interests of members and the public.	The governors produce a membership strategy which is supported by the trust. The governors have a membership and engagement group. The trust holds annual membership meetings. The trust involves the governors on material strategic proposals through the full council meetings.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.1.	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	YES	The Trust's communications team is developing a communications and engagement strategy that sets out its key audiences and stakeholders and how the boards of directors will communicate with them. The ambition of the strategy is to continually seek closer working relationships with key external stakeholders and partners within the healthcare community through the Our Dorset Integrated Care System as we seek to implement the Clinical Services Review.
E.1.2.	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g., Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).	YES	Stakeholder engagement will be an integral part of the Trust's communications and engagement strategy. (see C.1.b). Refer to constitution.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.3.	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	YES	Council of governors' minutes are available to board members upon request. Council of governors invite board of directors to their meetings. The senior independent director attends sufficient meetings (generally, the full council meetings and the annual members' meeting). Council of governors invited to meet board of directors, present questions to the board at their monthly meetings and attend a briefing after the part two of the meeting. A regular Governor Briefing is provided to governors.
E.1.4.	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	YES	Contact processes on website, staff and membership newsletter and within the annual report.
E.1.5.	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	YES	Board engagement with council of governors policy statement. (Register D7) The annual report states how many council of governors meetings the board of directors have attended during the year.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.6.	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	YES	An annual membership report is presented to the board of directors as part of the annual report.

Relevant statutory requirements		Compliance Y/N	Evidence or Non Compliance Explanation
E.1.7.	The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	YES	Part 1 Board meeetings and the annual meeting are open to the public. The constitution provides for members of the public to be excluded from a meeting for special reasons.
E.1.8.	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting.	YES	The Trust holds such a meeting annually.

E.2 Co-operation with third parties with roles in relation to NHS foundation trusts

Main Principles		How Applied
E.2.a.	The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.	The board of directors shall ensure the trust co-operates with relevant organisations. The board shall receive an annual report on the effectiveness of third party processes and relationships.

Supporting Principles		How Applied
E.2.b.	The board of directors should enter a dialogue at an appropriate level with a range of third party stakeholders and other interested organisations with roles in relation to NHS foundation trusts based on the mutual understanding of objectives.	The board of directors shall enter a dialogue at an appropriate level with a range of third party stakeholder and other interested organisations with roles in relation to NHS foundation trusts based on the mutual understanding of objectives and maintain a register of third party organisations and their objectives in relation to the trust.

Code provision		Compliance Y/N	Evidence or Non Compliance Explanation
E.2.1.	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	YES	Working schedule maintained by Associate Director of Communications (Register D19)
E.2.2.	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	YES	Working schedule maintained by Associate Director of Communications which was presented to the Board in March 2022. (Register D19)

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.3

Subject:	UHD FT Board Assurance Framework (BAF)
Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer
Purpose of paper:	The Board Assurance Framework is a systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.
Background:	The 2021/22 BAF for UHD was presented to the Board of Directors and approved at its meeting in June 2021. A six-monthly report (end of Q2 2021/22 position) of the Board Assurance Framework for University Hospitals Dorset NHS Foundation Trust was presented at the Board of Directors on 24 November 2021. An end of year Q4 report is provided to the Board for approval. A new BAF 2022/23 will be produced in line with the newly approved Board objectives for 2022/23. The BAF 2022/23 will be presented to the next meeting of the Audit Committee.
Key points for members:	For approval
Options and decisions required:	For approval
Recommendations:	For approval
Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	All
BAF/Corporate Risk Register: (if applicable)	BAF
CQC Reference:	Well Led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	19 May 2022
Quality Committee	23 May 2022

Principle objective	Specific Objective	Executive Director Lead	Risk Lead	Risk Register Ref	Risk Title / Description	Q1 Risk Rating	Q2 Risk Rating	Q4 Risk rating	Last Update	Monitoring Group	Target Risk Rating	
To be a great place to work, by creating a positive and open and inclusive culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.	1.1 To To engage with staff at all levels to ensure we maintain focus and realise the Health, Wellbeing and Covid-recovery needs and priorities of all our people, investing in appropriate provision of holistic interventions and resources.	Chief People Officer (KA)	Carla Jones Deputy Director of Workforce & Organisational Development, Deborah Matthews Director of Improvement and OD	1493	Absence, Burnout and PTSD - Risk of medium and long-term impact of Covid 19 on the health and wellbeing of the workforce due to burnout and PTSD which may potentially lead to high levels of sickness absence and the requirement for significant sustained support	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[11/04/2022] Referrals to OH remain high. Currently a 6/7 week wait for an appointment with an OH Nurse Adviser or OH Doctor due to low staffing levels and sickness absence within the team. All waiting referrals currently being reviewed and prioritised. Recruitment to the additional roles recently approved has commenced and one appointment made to date. Demand for psychological support & counselling service is high. The team remain under capacity due to staffing gaps and at present are unable to meet demand with referrals continuing to be redirected to the ICS Wellbeing Hub. A successful recruitment campaign has taken place to recruit Health & Wellbeing Practitioners to the bank and agreement has been obtained from the executive to extend the enhanced phased return to work (12 weeks) until end of March 2023, to support staff returning from periods of long term absence due to stress and mental health.	• Workforce Strategy Committee	S(2) x L(2) = 4 Low Risk	
	1.4 To deliver the trust's People Strategy by developing effective and responsive People services, policies and practices for each stage of the employee cycle. This will include workforce planning, recruitment and retention, training and education, employee relations, temporary workforce and workforce systems.	Chief People Officer (KA)	Carla Jones Deputy Director of Workforce & Organisational Development, Louise Hamilton-Welsh, Head of HR Strategy	1492	Resourcing Pressures - Staffing. Risk of significant resourcing pressures in the remainder of the Covid 19 pandemic and recovery period due to limited number of trained front line staff, likely increase in turnover as soon as the pandemic eases and limited pipeline of new recruits which is also impacted by the uncertainty around retaining EU employees and continuing to recruit from the EU.	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[19/04/2022] Validation of the merged ESR data is being prioritised, with initial focus being on areas where workforce transformation or configuration is due more imminently. Data cleanse for Pathology is well under way with support from the HR Business Partner. Nursing Workforce have reviewed the Medical care group HCSW establishment for further cost centre updates. A large scale cleanse of Right to Work and Visa dates on ESR is also taking place, following historic changes to which fields and what data is recorded.	• Workforce Strategy Committee	S(2) x L(2) = 4 Low Risk	
To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets.	2.1 Agree and deliver a sustainable budget, including Cost Improvement Programme (CIP) and merger savings programme	Chief Finance Officer (PP)	Peter Papworth	1584	Financial Control Total 2021/22 - Trust at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit and an unplanned reduction in cash available to support the capital programme	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	30/03/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
		Chief Finance Officer (PP)	Peter Papworth	1585	ICS Financial Control Total 2021/22 - ICS at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit and an unplanned reduction in cash available to support the capital programme	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	30/03/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
		Chief Finance Officer (PP)	Peter Papworth	1594	Capital Programme Affordability (CDEL) - Risk that the agreed capital programme will not be affordable within the ICS capital allocation (CDEL) resulting in operational and quality/safety risks and a delay in the reconfiguration critical path.	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	30/03/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	

		Chief Finance Officer (PP)	Peter Papworth	1595	Medium Term Financial Sustainability Risk that the Trust will fail to deliver a financial break-even position resulting in regulatory intervention, an unplanned reduction in cash and the inability to afford the agreed 6 year capital programme.	S(4) x L4)=16 High Risk	S(4) x L4)=16 High Risk	S(4) x L4)=16 High Risk	30/03/2022] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
	2.2 To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and emergency care	Chief Nursing Officer (PS)	Paul Bolton	1383	Given the nature of the novel coronavirus, there is a risk that patients and/or staff could contract hospital acquired covid-19 infection as a result of inadequate or insufficient infection prevention and control processes and procedures, which may not be known due to evidence base available at the time of the pandemic	S(4) x L (2) = 8 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	[18/02/2022)- new IPC guidance updated, no further changes from previous update except learning from Covid-19 outbreak being implemented, new variant in Dec 2021, vaccination and booster programme for colleagues in place. Continue to be part of the SW and Dorset IPC cells.	Quality Committee, Infection prevention and control group	S(4) x L (2) = 8 Moderate Risk	
		Chief Operating Officer (MM),	Jordan, Sophie - Associate Director - Operations, Flow and Facilities	1342	The inability to provide the appropriate level of services for patients during the COVID-19 outbreak - There is potential for this outbreak to create a surge in activity with resultant pressure on existing services. Risk to personal health if staff contract Covid-19 Risk to the organisation relating to staffing gaps (medical, nursing, AHP, ancillary) due to social isolation requirements and sickness. Risk of Covid-19 positive patients presenting to main hospital services causing risk from spread of infection Risk of delays to patient care in ED due to staff/beds being required for suspected Covid-19 patient testing and care of multiple or frequent patient presentations. Risk of insufficient isolation beds for suspected/confirmed Covid-19 cases	S(5) x L(3)=15 High Risk	S(4) x L(4)=16 High Risk	S(4) x L(4)=16 High Risk	[10/03/2022] Restrictions have been removed however there remains risk to operational delivery as staff continue to be symptomatic and are required to isolate. High levels of Covid patients across the wards impacting on elective and emergency flow. Tactical continues to meet daily and supporting cells in place (Blue pathway and IPC Cell)	Quality Committee, Infection prevention and control group	S(3) x L(2) = 6 Low Risk	

	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and emergency care	Chief Operating Officer (COO)	Judith May	1074	Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2020/21 are not met There is a risk that there will be patient harm from delayed pathways, NHSI/E regulatory challenges and premium expenditure requirements if the RTT related targets for 2020/21 are not met, namely: 1) Total waiting list to be no greater than Jan 2020 2) No 52 week waiters 3) RTT delivers to agreed operational plan trajectory for 2020/21 4) Recognise RTT standard is 92% (national NHS constitution target) and should be delivered where possible	S(4) x L(5)=20 High Risk	S(4) x L(5)=20 High Risk	S(4) x L(5)=20 High Risk	[20/04/2022] No significant change to risk. Numbers of 52/78 and 104 week waits continue to reduce and RTT performance stabilised however national standards not met. some specialities achieving 18 weeks. Clinical validation programme continues to ensure accurate waiting list and prioritisation of patients according to clinical need. Continue focus to treat long waiters.	• Finance and Performance Committee	S(2) x L(2) = 4 Low Risk	
	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, **cancer**, diagnostics and emergency care	Chief Operating Officer (COO)	Alison Ashmore	1386	Cancer waits - Risk of patient harm from delayed pathways, risk to compliance with CWT standards. Risk may be increased if unable to recruit and retention of key clinical staff (oncologist and histopathologists) in particular in sub specialisation areas that rely on a single handed practitioner.	S(4)xL(4) = 16 , Moderate Risk	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[11/04/2022] Structured pathway reviews for Breast, Gynae, Head & Neck, Colo, Prostate & Skin being undertaken by PwC. All timed pathways are being reviewed, admin processes being revisited, Demand & Capacity is being reworked, Business Information Structure & content being updated and implemented. Pathway and patient review carried out weekly at scheduled PTL breach meeting. Meetings are divided into risk areas for discussion - Operational management teams are in attendance therefore all risks are escalated in a timely manner. Holistic approach to pathway management introduced, looking at recurrent and adhoc capacity provision to mitigate delays to the pathway and reduce potential for patient harm. Monthly meetings scheduled with Operational Management and Diagnostic Service Management to review on an ongoing basis. [08/04/2022] Review of all Root Cause Analysis during April 2022 to ensure ongoing monitoring of any potential clinical harm	• Finance and Performance Committee	S(2) x L(2) = 4 Low Risk	
	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, **diagnostics** and emergency care	Chief Operating Officer (COO)	Alex Lister	1348	Covid related pause to Dorset Bowel Cancer Screening Programme and potential diagnostic delay	S(4) x L (3) = 12 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	S(2) x L(3) = 6 Low Risk	[19/04/2022] Diagnostic wait standard was not met in February 2022 (71%), however, since then the additional lists provided by insourcing weekends at Poole has mitigated the loss of capacity on the RBH site due to the ventilation work. Subsequently the diagnostic wait standard was met at 97% for March 2022. There is one further insourcing weekend scheduled at Poole in April and from beginning of May the RBH lists will return to the RBH site.	Finance and Performance	S(2) x L(3) = 6 Low Risk	

	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and **emergency care**	Chief Operating Officer (COO)	Tanner, Mandy - Radiology General Manager	1574	Breast screening backlog - There is currently a significant backlog with 20,000 women waiting for breast screening in Dorset and just 3.9% of women eligible are being offered screening. If this continues women will present later with breast cancer as 7-10% of every 1000 patients screened have cancer detected early. The earlier the condition is found the better the prognosis and the less likely the patient is to need major surgery and treatments such as chemotherapy	S(4) x L(4)=16 High Risk	S(4) x L(4)=16 High Risk	S(4) x L(4)=16 High Risk	[20/04/2022] Update from DBSU-no improvement, Covid impacting and trainees in post but not yet able to work alone.	Finance and Performance	S(2) x L(2) = 4 Low Risk	
		Chief Operating Officer (MM)	Alex Lister	1429	Ambulance handover delays - If we cannot assess and move patients into ED clinical areas from the Ambulance queues within 15 minutes then there is a risk of harm to patients in the queue or community. See attached PDSA documents. There is also a risk to organisational performance standards and reputation	S(5) x L(3)=15 High Risk ,	S(4) x L(4)=16 High Risk ,	S(4) x L(4)=16 High Risk ,	[21/01/2022] Change in agreed SWAST drop off, currently working through an SOP and staffing models for both sites additional trained being added to the template to try and cover. Looking to the organisation for support but on=going risk.	Finance and Performance Committee	S(3) x L(1) =3, Very Low Risk	
		Chief Nursing Officer (PS), Chief Operating Officer (MM)	Leanne Aggas	1430	Emergency Department Workforce - Post COVID-19. Whilst there is a requirement to maintain compliance within current COVID pathways within ED services then there will be a nursing vacancy gap of 50 WTE (Total establishment 160 WTE proposed 104 WTE Funded). There is a potential risk to patient safety, finance and performance This will result in high usage of agency staff posing a performance/ finance and safety risk.	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[10/03/2022] Overall ED vacancy has reduced to within acceptable limits. There is a financial risk and training risk with high numbers of recruits and working within an expanded footprint.	Finance and Performance Committee	S(3) x L(1) =3, Very Low Risk	
	2.3 To continue to deliver efficiency and productivity opportunities using Getting it Right First Time (GIRFT) and Model Hospital benchmarking data, in the context of the Covid-19 response. This includes resetting services in ways to reduce unwarranted variation in our clinical and non-clinical services both across sites and between services	Chief Medical Officer (AOD)	Rushforth, Helen - Head of Productivity and Efficiency	1416	GIRFT and Model Hospital Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision.	S(3) x L (3) = 9 Moderate Risk	S(3) x L (4) = 12 Moderate Risk	S(4) x L(4)=16 High Risk	[04/04/2022] Reviewed and confirmed risk remains the same	Finance and Performance Committee	S(3) x L(2) = 4 Low Risk	

	2.4 To agree and publish the multi-year Green Plan, to measure, and reduce our carbon footprint, improve air quality and make more sustainable use of resources as part of a multi-year sustainability strategy. This is to be developed by the Trust and agreed by the Board by July 2021 and progress reported to the Board by March 2022	Chief Strategy and Transformation Officer (RR)	Davies, Edwin - Associate Director Capital and Estates	1446	Sustainability Strategy If we do not deliver the Trust's Sustainability Strategy there is a risk that the Trust will not either measure or reduce it's carbon footprint	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[07/01/2022] Udate ED - Multi-agency strategy in place. Sustainability Committee - chaired by NED Part of Pan - Dorset Sustainability Group	Sustainability Committee	S(2) x L(2) = 4 Low Risk	
To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience	3.1 To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Fluid management for inpatients As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Dr D Tiwari	1473	Safe Fluid management - If we are not able to safely prescribe and administer appropriate fluids, in the correct volumes and accurately monitor fluid balance and patient physiology there is significant risk to patient safety	S(3)x L(4) = 12 , Moderate Risk	S(3)x L(4) = 12 , Moderate Risk	S(3)x L(3) = 9 , Moderate Risk	[05/04/2022] IV fluid QI group has made good progress and is now rolling out the next iteration of the IV fluid prescription form Fewer incidents being logged and fewer ME comments since this project has begun	Quality Committee, Quality Goverance Group	S(2) x L(2) = 4 Low Risk	
	To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Escalation of deteriorating patients As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Chief Medical Officer	1605	Managing the deteriorating patient - if the Trust is unable to develop a unified policy and process for the monitoring, escalation and management of a deteriorating patient then there is a risk to patient safety and patient outcomes.	S (4) x L (3) = 12 Moderate Risk	S (4) x L (3) = 12 Moderate Risk	S (4) x L (3) = 12 Moderate Risk	[04/04/2022] Risk to be reviewed ongoing incidents but frequency less than QI project will continue into next year but substantial project made with almost all sub-groups Resus committees now aligned and new framework for emergency calls across UHD out for final consultation before launch Comms plan in place	Quality Committee, Quality Goverance Group	S (3) x L (3) = 9 Moderate Risk	
	To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Urgent IV access As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Dr D Morgan, Dr Holloway, Dr Spake	1598	If staff are not sufficiently trained or experienced to manage, escalate and/or ensure IV access for patients then risk to patient safety and outcomes.	S (3) x L (3) = 9 Moderate Risk	S (3) x L (3) = 9 Moderate Risk	S (3) x L (3) = 9 Moderate Risk	[01/03/2022] As at the end of Feb 2022. The new UHD DIVA SOP will be submitted to ratification to CGG and PPG in March 2022. A 6-month trial of the new UHD DIVA pathway is scheduled to commence at both Poole and Bournemouth sites from April 2022 having established DIVA teams and an associated referral process/criteria – including the introduction of a new intermediate length ultra-sound guided cannula. An e-Form has also been created to automate the addition of a CPI flag to EPR for patients identified as being at risk of Difficult Intra-Venous Access.	Quality Committee, Quality Goverance Group	S (2) x L (2) = 4 Low risk	
	To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Safety checklists for procedures As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Joanne Sims, Dr Holloway	1599	If unable to embed culture for use of safety checklist process for all interventional procedures undertaken across UHD then risk of never events occuring with potential harm to patients and regulatory action from CQC. Risk that variable application across UHD and lack of standardisation across sites for same specialities, including staff training, will impact on compliance and culture .	S (4) x L (3) = 12 Moderate Risk	S (4) x L (3) = 12 Moderate Risk	S (3) x L (3) = 9 Moderate Risk	[15/02/2022] Current number of Never events reported in 21/22 less than YTE 20/21 - decision to reduce likelihood risk rating to 3 resulting in change in oerall risk rating to 9.	Quality Committee, Quality Goverance Group	S (3) x L (2) = 6 Low Risk	

	To deliver 4 priority clinical Quality Improvement (QI) programmes as well as supporting clinical and non-clinical QI work across the Trust.	Chief Nursing Officer (PS)	Paul Bolton	1463	Prevention of healthcare associated gram negative blood stream infections. There is a potentially avoidable risk of patient harm for those patients who contract hospital acquired gram negative infections.	S(2)xL(3) = 6 , Low Risk	S(2)xL(3) = 6 , Low Risk	S(2)xL(3) = 6 , Low Risk	[28/06/2021] Current rising rate of HCAI cases across UK and SW. QI group set up in SW to review the learning planned in the next few months. No further changes required.	• Infection Control Group	S(2) x L(2) = 4 Low Risk	
		Chief Nursing Officer (PS)	Paul Bolton	1383	Given the nature of the novel coronavirus, there is a risk that patients and/or staff could contract hospital acquired covid-19 infection as a result of inadequate or insufficient infection prevention and control processes and procedures, which may not be known due to evidence base available at the time of the pandemic	S(4) x L (2) = 8 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	[18/02/2022] new IPC guidance updated, no further changes from previous update except learning from Covid-19 outbreak being implemented, new variant in Dec 2021, vaccination and booster programme for colleagues in place. Continue to be part of the SW and Dorset IPC cells.	Quality Committee, Infection prevention and control group	S(4) x L (2) = 8 Moderate Risk	
		Chief Nursing Officer (PS)	Paul Bolton	1172	There is a risk that if the Trust does not meet contractual targets for monitored organisms, this may result in patients acquiring hospital infections, loss of confidence with patients and public and reputational damage.	S(3)xL(3) = 9, Moderate Risk	S(3)xL(3) = 9, Moderate Risk	S(3)xL(3) = 9, Moderate Risk	[18/02/2022]- Existing controls remain in place - remains part of the Dorset/SW wider IPC cell and quality improvement work in these areas. PIRs continue with learning shared.	• Infection Control Group	S(3) x L(2) = 6 Low Risk	
		Chief Medical Officer (AOD)	Chief Medical Officer (AOD)	1607	It the Trust fails to maintain hospital standardised mortality metrics at as or below “expected” levels it is probable that there are identified(and unidentified) and unmitigated risks to patient safety and patient outcomes. This brings the additional risk of reputational damage, damage to public confidence and regulatory scrutiny	S(4)xL(3) = 12, Moderate Risk	S(4)xL(3) = 12, Moderate Risk	S(4)xL(3) = 12, Moderate Risk	[04/04/2022] Mortality ratios stable Ongoing deep dives into areas of concerns and to understand the disparity between sites #NOF and complex learning to form the basis of QI workstream for next year including 7 day working, ward cover, theatre utilisation, consultant job planning etc	Quality Committte, Mortality Surveillance Group	S(3) x L(1) = 3, Very Low Risk	

	3.2 To redesign and transform our outpatient pathways, with a Digital First offer, improving access to care, reducing travel times, and supporting patients through and changes.	Chief Operating Officer (COO)	Sarah Macklin	1464	Re-designing outpatient services for future demand Risk that the Trust fails to respond to the challenge of changing models of outpatient care in line with National trend information relating to population growth and aging population needs. Developing innovation and new models of care is essential to future-proof access to relevant clinical intervention and advice in a timely way.	S(3)x L(3) = 9 , Moderate Risk	S(3)x L(3) = 9 , Moderate Risk	S(3)x L(3) = 9 , Moderate Risk	[08/03/2022] PA Consultancy review underway for the outpatient enabling excellence programme review of works and recommendations. The implementation phase is in progress and from this outcome recommendations will be worked through with the teams and the specialties. The digital transformation programme is working through the procurement process in terms of the following: Patient Portal - 2 way booking system to support patients to manage their own care and gain access to their clinic appt information, Virtual Consultation platform, Digital Dictation for outpatients via DRAGON to support real time letters to GP and patients, Bookwise clinic room scheduling system for Poole site to optimise clinic room utilisation, INTOUCH system for flow management of patients on the RBCH sites in line with PGH. All these strategies will support streamlining our processes and provide efficiencies and better experiences for staff and patients.	Finance & Performance Committee	S(2) x L(2) = 4 Low Risk	
		Chief Operating Officer (COO)	Michele Roberts	1242	Risk relating to the continuity and operational performance of outpatients as a result of reduced staffing - The Outpatient department is experiencing increasing levels of work in respect of volume of amendments, clinic cancellations, delays in the pre-reg of patients. This compromises optimum patient care and impacts on RTT. Staff are impacted by increased workloads and risk to wellbeing.	S(2) x L(3) = 6 , Low Risk	S(3)x L(3) = 9 , Moderate Risk	S(3)x L(3) = 9 , Moderate Risk	[20/04/2022] Discussed at the OPD quality and risk group. Improvement in staffing within the admin team. For rating review and further detail to be added by General Manager.	Finance and Performance	S(2) x L(2) = 4 Low Risk	
		Chief Operating Officer (COO)	Darren Jose	1292	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	[08/04/2022] Progress with PA Consultancy (report PPT attached), work on-going.	Finance and Performance	S(3)x L(3) = 9 , Moderate Risk	
	3.3 To implement the elective care priority programmes for Dorset, so as to improve quality and sustainability of these services: • Ophthalmology	Chief Operating Officer (COO)	Barry Alborough - Duell, Directorate Manager	1442	Ophthalmology: achieving eye theatre efficiency of 85%	S(2) x L(3) = 6 , Low Risk	S(2) x L(3) = 6 , Low Risk	S(2) x L(3) = 6 , Low Risk	[18/04/2022] Directorate review and discussion Royal College of Ophthalmology document in regards to high volumes cataract surgery .High volume lists having 8 patients with a trainee and 10 patients without a trainee. Asking IPC in regards to Eye day case area increasing patients capacity. Clinicians review use Anaesthetic eye drops instead of injections.	• Finance & Performance Committee • Ophthalmology Directorate Governance Group	S(1) x L(2) = 2, Very Low Risk	
		Chief Operating Officer (COO)	Barry Alborough - Duell, Directorate Manager	1476	Backlog of overdue follow up patients.There is a risk to the positive outcome for patients who are unable to be seen with planned FU timescales	S(3)x L(3) = 9, Moderate Risk	S(3)x L(3) = 9, Moderate Risk	S(3)x L(3) = 9, Moderate Risk	[20/04/2022] SpaMedica Contract ready to commence. Plan to deliver follow-up clinics in progress .Spa Medica will allow us to release capacity for monthly follow ups.	• Finance & Performance Committee • Ophthalmology Directorate Governance Group	S(3) x L(2) = 6 , Low Risk	

	To implement the elective care priority programmes for Dorset, so as to improve quality and sustainability of these services: • Orthopaedics, as part of the Dorset wide MSK plans	Chief Operating Officer (COO)	West, John - General Manager, Trauma Orthopaedics, Surgery PH site	1439	Orthopaedic operational pressures ,outlying patients and reduced ward footprint. Potential lack of capacity to admit routine Orthopaedic Patients for their surgery creates inability to maintain or recover RTT position. This may lead to more complaints around compromising wellbeing of patients attributable to deteriorating access and waiting times. Operations may be cancelled when unable to maintain ringfenced bed base to meet GIRFT requirements. Demand has not reduced to the level previously anticipated following the introduction of MSK triage in 2017 and referrals have steadily increased after an initial fall. Additions to waiting list now exceed removals by an average of 37 patients per month in the past year	S(2)x L(5) = 10, Moderate Risk	S(2)x L(5) = 10, Moderate Risk	S(2)x L(5) = 10, Moderate Risk	[11/04/2022] full engagement with regional scheduling project with additional local service development eg. day case hip and knee replacement pathways.	Finance & Performance Committee	S(2) x L(3) = 6 , Low Risk	
	To implement the elective care priority programmes for Dorset, so as to improve quality and sustainability of these services: • Theatres	Chief Operating Officer (COO)	House, Nichola - Directorate Manager - Surgery - RBH site	1490	Lack of Hybrid Theatre. As part of the CSR, it was highlighted that there is a need for a Hybrid theatre. This issue was also recommended in the Vascular GIRFT report.	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[21/04/2022] The business case has been delayed owing to operational pressures. A clinical lead has now been appointed for the Vascular team who has identified this project as one of the transformation workstreams.	Surgical RAGG	S(1) x L(2) = 2, Very Low Risk	
	3.4 Improve Urgent and Emergency Care (UEC) flow and quality of care as measured by the new national UEC Emergency Department waiting time standard and same day emergency care outputs.	Chief Operating Officer (COO)	Alex Lister	1460	Urgent and Emergency Care (UEC) performance There is a potentional risk to patients waiting in excess of National Standards	S4) x L(5)=20 High Risk Increased Risk from 15 to 20 in Q1	S4) x L(5)=20 High Risk	S4) x L(5)=20 High Risk	[12/04/2022] Unchanged. Significant challenges with ED performance. Exec support with actions. Bi WEEKLY coo LED meeting reporting to Regional Team - Current Recovery plan attached.	• Finance and Performance Committee	S(2) x L(2) = 4 Low Risk	
	3.5 To reduce towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partners and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer (COO)	Jordan, Sophie - Associate Director - Operations, Flow and Facilities	1053	Lack of capacity for elective & non elective activity and risk to patient harm due to LLOS and NRTR patients	S(4) x L(5)=20 High Risk	S(4) x L(5)=20 High Risk	S(4) x L(5)=20 High Risk	[10/03/2022] The position is unchanged from last update. [09/12/2021] Update CB - Improvement has been seen in the number of patients with No Reason to Reside (NRTR). However, a sustained downward trend is variable. Additional care homes beds have been secured (total of 40), however, the capacity and flow of patients from UHD to the additional capacity is compromised through Covid outbreaks within care home settings across Dorset. Further national hospital discharge funding has been released and a number of further schemes including support to LA brokerage teams to "fast track" patients awaiting care home	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
		Chief Operating Officer (MM),	Jordan, Sophie - Associate Director - Operations, Flow and Facilities	1387	Demand & Capacity: Demand will exceed capacity for acute inpatient beds	S(3) x L(5)=15 High Risk Increased to 16 from 15 in Q1	S(4) x L(5)= 20 High Risk Increased to 20 from 16 in Q2	S(4) x L(5)= 20 High Risk	[10/03/2022] Reviewed - Occupancy remains extremely high across both sites, impacting on ED handovers and ability to move patients to appropriate beds in a timely fashion. Added pressures relating to Covid admissions/contacts and high number of MRFD patients across the acute wards has increased the risk level. Mitigating actions in place via the Hospital Flow improvement programme and through external UEC initiatives	Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	

		Chief Operating Officer (COO)	Jordan, Sophie - Associate Director - Operations, Flow and Facilities	1131	Current challenges around patient flow and capacity due to increased demand, delays in external discharge and bed closures have become increasing difficult to manage and presents risk to patient safety	S(3) x L(5)=15 High Risk Increased to 16 from 15 in Q1	S(4) x L(5)=15 High Risk Increased to 20 from 16 in Q2	S(4) x L(5)=15 High Risk	[13/04/2022] Update SW UHD SDEC Workstream now part of the flow recovery programme with oversight of TMG Weekly SDEC Workstream meetings to support the areas in developing services required throughout the organisation. Bids for further funding being compiled. All routes of access being reviewed to ensure robust access to the services from within and outside the organisation. SDEC lead working as part of the system SDEC group to ensure equity of provision and access. Close working with SWAST, DHUFT and CCG to further develop services and access	• Finance and Performance Committee	S(4) x L(2) = 8 Moderate Risk	
To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people	4.1 Strengthen and improve communications/engagement with staff, governors, patients, local people and key stakeholders through a communication and engagement plan, delivered over the year and reviewed by February 2022. A key focus is leading for Equality, Diversity and Inclusion strategy and our work as an ICS partner on reducing health inequalities	Chief Strategy and Transformation Officer (RR)	Chief Strategy and Transformation Officer (RR)	1466	Effective relationships with local partner To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	Closed as replaced with risk 1603					
	4.2 Support delivery of a continuously improving organisation and culture of improvement by developing a QI strategy and an innovation strategy. Implement the strategies across UHD and the Dorset ICS to improve outcomes and deliver efficiencies	Chief Strategy and Transformation Officer (RR)	Alan Betts	1600	If we do not deliver the Trust's QI and Innovation Strategy there is a risk that the Trust will not improve outcomes or deliver efficiencies in line with the Trust's values of being an improving organisation	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[04/03/2022] QI objectives for 2022-23 reviewed at Transformation and Improvement Group (TIG) Patient Safety Clinical Priorities supported at TIG and escalated to TMG for approval 22/3/22 QI strategy reviewed with QI team and progress to be reported in Q1 22/23, good progress on clinical priorities for 2021/22 Roll out of QI training and QI communications continuing	Transformation Committee	S(2) x L(2) = 4 Low Risk	
	4.4 Develop the Bournemouth University partnership, including the partnership strategy to be approved by Trust Board by July 2021 and implementing throughout 2021/22 and future years	Chief Strategy and Transformation Officer (RR)	Alan Betts	1601	If we do not continue to develop the partnership with Bournemouth University it may lead to a failure to fulfil our potential as University Hospital which may mean we don't continue to attract staff and research opportunities as a leading University Hospital	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[04/03/2022] Programme benefits continue to progress, partnership Board in place and regularly meeting. Aims for 22/23 agreed: collaborate on new roles for BU and UHD utilise UHD apprenticeship funding to co-deliver training to UHD leaders and managers develop match funded PhDs and student placements progress joint research strategy (inc CTU	Transformation Committee	S(2) x L(2) = 4 Low Risk	
To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	5.1 Develop a robust plan for reconfiguration to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2021, and teams being prepared and understanding their trajectory so they are ready with new models of care, and to occupy new estate when it is delivered.	Chief Strategy and Transformation Officer (RR)	SK	1602	Risk that In year delays to the critical path programme can lead to costs increasing by £0.5m a month. Complexity of the programme and external approvals required for capital expenditure generate the likelihood	S(5) x L(4) = 20 High Risk	S(4)xL(2) = 8 , Moderate Risk	S(4)xL(2) = 8 , Moderate Risk	[03/02/2022] No further update [10/01/2022] Now that FBC approval has been received, all risks and issues are being monitored by the Acute Reconfiguration Capital (ARC) Group on a monthly basis. That group is also sighted on any areas for escalation to ensure programme and relevant enabling works remain on track. Monthly Cost report also presented to monitor funding.	• Transformation Committee	S(4)xL(3) = 12 , Moderate Risk	

		Chief Strategy and Transformation Officer (RR)	Davies, Edwin - Associate Director Capital and Estates	1260	There is a risk that we are unable to maintain the Trust estate in line with Clinical and regulatory requirements. Risk to staff and patient safety and risk of regulatory action if statutory breaches identified. Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling	S(4)xL(3) = 12 , Moderate Risk	S(4)xL(3) = 12 , Moderate Risk	S(4)xL(3) = 12 , Moderate Risk	[25/03/2022] progress continues at pace. Aggregated review undertaken and evidence of status and compliance improving	Quality Committee	S(4)xL(2) = 8 , Moderate Risk	
	5.2 Establishing robust arrangements for taking forwards Health Infrastructure Plan with Dorset partners and NHSI/E, such that Dorset programme business cases start to be submitted in 2021/2 including the new entrance, ward refurbishments and that options appraisals on other cases are completed	Chief Strategy and Transformation Officer (RR)	Chief Strategy and Transformation Officer (RR)	1604	Risk of delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds in sufficient time to enable the wider reconfiguration by 2024/26. Risk is delayed benefits by later than planned reconfiguration. Securing NHP enabling funds required in year to allow progression of key capital works	S(4) x L(4) = 16 High Risk	S(4) x L(4) = 16 High Risk	S(4) x L(4) = 16 High Risk	30/03/2022: Update SK Risk remains on register for monitoring. OBC target date remains as June 22 so there are currently no long-term inflation concerns. For review in June.	• Transformation Committee	S(4) x L(2) = 8, Medium Risk	
	5.3 Under the national requirements for establishing a new Dorset ICS, work with system partners to develop a provider collaborative across Dorset and help to shape the Dorset Integrated Care System as it transitions onto a statutory basis from April 2022.	Chief Executive (DF)	Chief Strategy and Transformation Officer (RR)	1603	The risk is establishing the Statutory ICS by April 2022 in a way that has effective governance and relationships that deliver against the 4 ICS objectives:- - improving population health and healthcare; - tackling unequal outcomes and access; - enhancing productivity and value for money; and - helping the NHS to support broader social/economic development) Failure to achieve the above leads to UHD being unable to fulfil its requirements and regulatory compliance.	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[04/03/2022] Workstreams continue and ICS/ICB due to go live July 21 Current execs of CCG not appointed to ICS positions - risk of loss of organisational memory combined with opportunity for change in strategy Provider collaborative delayed and programme re-started Feb 2022 Likely that ICS will be meeting minimum standards from 1st July - unclear of impact of ICS strategy on UHD at present time	• Board of Directors	S(2) x L(1) = 2, Very Low Risk	
	5.4 Play an active part in the key Dorset transformation plans programmes, including Digital Dorset, by implementing four core clinical applications (Dorset Care Record, order communications, electronic prescribing and medicines administration, health of the ward) and support the clinical leaders of these programs transform clinical processes to achieve the maximum benefit from these investments; migrate all devices to Windows10, stabilise the underlying infrastructure and mitigate against all IT security threats	Chief Informatics and IT Officer (PG)	Martin Davis, IT Security Manager	1273	Cyber Security Risks, Threats and Vulnerabilities- There are risks related to cyber security that, potentially, can affect the resilience of the Trust's IT systems and data. This could adversely affect all trust business.	S(2)xL(4) = 8 , Moderate Risk	S(4) x L(5)= 20 High Risk Increased to 20 from 8 in Q2	S(2) x L(5)= 10 Moderate Risk	[29/03/2022 - Controls reviewed and assessed. Grading adjusted 02/02/22 The risk rating has been reduced following the previous rating rise dated 11/08/2021 as the number of unsupported (obsolete) operating systems at UHD has decreased to with accepted levels for the Data and Security Protection Toolkit. Although the risk score has not been decreased back the previous rate of 8 due to the ongoing risk of a cyber attack and the continued number of known vulnerabilities on Trust IT systems.	Information Governance Group	S(2)xL(3) = 6 , Low Risk	
		Chief Informatics and IT Officer (PG)	Sarah Hill	1434	Delays to the implementation of the Dorset Care Record	S(3)xL(2) = 6 , Low Risk	S(3)xL(2) = 6 , Low Risk	S(3)xL(2) = 6 , Low Risk	[21/01/2022] Pathology testing under way and testing will be done alongside the EPR change to ensure both projects progress with single testing support. MyDCR is further delayed with no clear date at this time.	Information Governance Group	S(2)xL(3) = 6 , Low Risk	

		Chief Informatics and IT Officer (PG)	Russell King	1437	There is a risk of total outage of the computing services at RBCH if the single point of failure of electrical supply fails	S(3)xL(1) = 3 , Very Low Risk	S(4) x L(3)= 12 Moderate Risk Increased to 12 from 3 in Q2	S(2)xL(3) = 6 , Low Risk	[02/02/2022] All Virtual servers have now been migrated from RBH to PH, leaving just the physical boxes of which the most critical is CaMIS which is not resilient. A new risk entry will be raised for that.	Information Governance Group	S(1)xL(1) = 1 , Very Low Risk	
		Chief Informatics and IT Officer (PG)	Chief Informatics and IT Officer (PG)	1298	There is a risk that we fail to maintain and develop the Trust IT services in line with clinical and operational requirements	S(5)xL(2) = 10 , Moderate Risk	S(5)xL(2) = 10 , Moderate Risk	S(5)xL(2) = 10 , Moderate Risk	[02/09/2021] Wifi work is now delayed to November 2021. Workload continues to be a challenge within the team.	Information Governance Group	S(4)xL(2) = 8 , Moderate Risk	
		Chief Medical Officer (AOD)	Sarah Hill, Assistant Director of IT Developmen	1378	Lack of Electronic results acknowledgement system - A lack of an electronic results acknowledgement system for requested clinical tests is a risk to patient safety and could result in missed diagnosis and suboptimal treatment.	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	[04/04/2022 13:19:18 Alyson O'Donnell] No further updates but no live issues of reported issues - those reported historical. Gaps in visibility of results between organisations improved with development of LIMS	Information Governance Group	S(2) x L(1) = 2, Very Low Risk	
		Chief Informatics and IT Officer (PG)	Axtell, Camilla - IG and Data Protection Officer	1591	Information Asset Management.There is a risk of data loss and/or service interruption as a result of the inadequate management of the large suite of Information Assets that contain Personal Identifiable Data.	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	[06/04/2022] Around 80% compliance was achieved by end December 2021 but this has now slipped back as a result of the need for annual assurance for some of the requirements. TMG to be engaged to consider the appetite for performance management of this requirement in the	Quality Committee, Information Governance Group	S(3)xL(2) = 6 , Low Risk	
		Chief Informatics and IT Officer (PG)	Sarah Hill Assistant Director of IT Development	1592	Electronic Prescribing and Medicines Administration Project Delay. There is a risk that the EPMA project will be significantly delayed as a result of Covid 19 and the availability of a signed off version of the software from the vendor (Wellsky). This will increase the overall costs of the project beyond its project budget and delay the clinical benefits.	S(4) x L(4)=16 High Risk	CLOSED			Quality Committee, Information Governance Group	S(3)xL(2) = 6 , Low Risk	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 April 2022

Agenda item: 8.5

Subject:	Quality Impact Assessment Policy

Prepared by:	Helen Rushforth, Head of Productivity and Efficiency
Presented by:	Helen Rushforth, Head of Productivity and Efficiency

Purpose of paper:	For Approval
Background:	Following the Francis report into Mid-Staffordshire hospitals and the subsequent Kirkup review of Liverpool Community Trust it is considered critical that all Trusts have a robust Quality Impact Assessment approach to mitigate against the risks of decisions made on a financial basis having an adverse effect on quality. The strategy attached is based on best practice guidance.
Key points for members:	The QIA process is a fundamental part of the Trust's approach to decision making. The QIA Review Group (Chief Medical Officer, Chief Nursing Officer and Associate Director of Risk and Quality Governance) should sign off all schemes and if necessary can stop a scheme continuing.
Options and decisions required:	No options for consideration
Recommendations:	The Board is requested to approve the QIA Policy.
Next steps:	Continued implementation of strategy and process

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
Quality Committee	25 April 2022

University Hospitals Dorset
NHS Foundation Trust

Quality Impact Assessment

If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version.

Out of date policy documents must not be relied upon.

A) EXECUTIVE SUMMARY POINTS
• QIA is a fundamental process for us to provide assurance that changes made will not have an adverse impact upon the quality of care provided to our patients
• All projects should have an assessment which considers the domains identified within this document although this may take different forms
• Assessments should be considered by the appropriate forum e.g. ward template review, Clinical Assurance Group, Transformation Group, QIA panel
B) ASSOCIATED DOCUMENTS
• Quality Impact Assessment form

C) DOCUMENT DETAILS	
Author:	Helen Rushforth
Job title:	Head of Productivity and Efficiency
Directorate:	Strategy and Transformation
Version no:	2
Equality impact assessment date:	19/11/2021
Target audience:	
Approving committee / group:	Quality Committee
Chairperson:	
Review Date:	

D) VERSION CONTROL

Date of Issue	Version No.	Date of Review	Nature of Change – (include section reference)	Approval Date	Approval Committee	Author

E) CONSULTATION PROCESS

Version No.	Review Date	Author	Level of Consultation
2	19/11/21	Helen Rushforth	Update for changed processes

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1 Introduction

1.1 Inadequate QIA processes coupled with poor overall clinical engagement and limited board involvement in the process result can all lead to increased risks to quality.

1.2 The need for a robust assessment on the impact on quality of proposed savings plans, or indeed any service change, comes at a time when there are significant financial pressures. Following a sustained period of efficiency requirements CIP is increasingly challenging to identify and deliver and tends to be more transformational (and therefore impactful) than previously.

1.3 The scandal at Mid-Staffs Foundation Trust and subsequent report identified 'focus on cost containment and improving efficiency (without due regard for impact upon service provision) … as one of the key drivers of the resultant poor care'. As a result Trusts were mandated to develop a robust approach to ensuring that cost improvement plans did not adversely impact upon the quality of care delivered by the organisation.

1.4 Despite the Mid-Staffs report a subsequent report into Liverpool Community Trust further emphasised the need for full clinical and operational engagement with the QIA process. The report states that 'CIPs were poorly designed, with significant impacts on services and staff, and implemented with rudimentary QIAs.'

1.5 The need for a formal quality impact assessment process is essential in a system as complex and interdependent as the NHS, where decisions in one part of the service can impact upon another with many co-dependencies that are not always easy to predict or assess.

1.6 Trust Boards should not be approving any such schemes, or indeed overall financial plans, without first receiving appropriate assurances that the impact of the proposed changes on quality are in the worst case neutral but at best should be aiming for an improvement in quality.

1.7 Quality must remain at the heart of everything we do despite the efficiency requirements within the NHS. Quality can be protected and even enhanced whilst we work to contain cost, but this is not always the case and we must not assume that because nobody wishes to compromise on quality, this will not happen.

1.8 It is important to have a process in place to ensure that any service changes do not have an adverse impact on quality of care delivered to our patients or service users. The QIA process has been developed to ensure that we have the appropriate steps in place to safeguard quality whilst delivering significant changes to service delivery. This process should be used to assess the impact that any individual CIP, service development or improvement project may have on the quality of care provided to patients and service users at UHD.

2 Purpose/Policy Statement

2.1 This document provides a framework for the Quality Impact Assessment (QIA) process.

2.2 It helps outline:

- the opportunities and risks linked to quality and safety that plans, projects and proposals may present
- what mitigation or management actions may be required

2.3 Reporting the outcome of quality impact assessments to the Board of Directors will enable it to fulfil its corporate responsibility for ensuring that cost improvement plans and service changes are not detrimental to the quality of services.

2.4 The policy applies to all significant cost improvement schemes, skill mix reviews, estates changes, service change and service development proposals and plans and any other projects which may impact on services.

2.5 In June 2012 the National Quality Board provided guidance with detail on how it would expect Trusts to manage the impact on quality of service improvement. The guidance clearly outlines the expectation that Trusts will:

- articulate the risks and impact to quality using a risk assessment matrix;
- formalise the role of the Board and specifically the Chief Medical and Nursing Officer in their leadership of this process; emphasising the importance that the QIA process is Board-led;
- confirm how red and amber risks to quality will be handled within the process;
- include measurements on quality relating to the proposed change (quality metrics and metrics to provide assurance within the performance framework).

3 Definitions

3.1 This document sets out the processes to be undertaken to ensure that the impact on quality is sufficiently considered throughout the decision-making process.

3.2 This process applies to all projects within the Trust's PEP (Productivity and Efficiency Programme) incorporating the CIP (Cost Improvement Programme), as well as all service improvement/transformation projects.

4 Consultation

4.1 Previous versions have been reviewed and approved by Finance and Performance Committee and Quality Committee.

4.2 Consultation for changes is via Chief Medical Officer, Chief Nursing Officer and Associate Director of Risk and Governance

5 Procedures/Document Content

5.1 A quality impact assessment should be populated during the development of the CIP. KPIs, risk ratings and mitigations should be assigned and agreed by the executive sponsor and the project lead and regularly challenged throughout the development phase. The risks associated with the deliverability of the schemes and the amount of financial savings to be delivered should also be assessed, risk rated and appropriate mitigations identified. A regular reassessment of the quality impact of CIP schemes should be an integral part of the monitoring arrangements by the Quality Impact Assessment Review Group.

5.2 We recognize that many CIP schemes are smaller scale and reflect changes in practice that have developed over time, however given the potential for cumulative impacts on our quality we require all schemes to have consideration of the potential impact upon quality documented.

5.3 Prior to QIA review, project leads must ensure that their PID and QIAs are signed off as appropriate. Sign offs will vary depending on the scale and complexity of the project and where they have potentially significant impacts must include appropriate clinical consideration. Project leads may be required to present their PID/QIA at the Review Group.

5.4 The QIA Review Group will obtain feedback against quality milestones from the schemes / projects and discuss escalated quality Issues. Quality issues which cannot be resolved will be escalated by the Chief Medical Officer and/or Chief Nursing Officer to the Quality Committee (or other Committees/Groups) as appropriate.

5.5 The QIA Review Group will ensure appropriate benchmarking information is made available wherever possible in order to triangulate assurances over viability and safety of any proposed scheme.

5.6 CIP schemes rejected at various points in the process should be recorded and reported. CIP schemes will remain dynamic in nature as they are introduced and therefore it is important that risk scoring accurately reflects any risks to quality and that the quality assurance metrics continue to act as an early warning indicator of deterioration in the quality of the service provided.

5.7 It is the collective responsibility of the Board of Directors to ensure that a full appraisal of the quality impact assessment is completed and recorded and that arrangements are put in place to monitor schemes.

5.8 At the point of sign off by the Board of Directors, all board members should ensure that each CIP scheme has evidence of a comprehensive risk assessment being completed on the quality impact assessment of each individual scheme. This should include assessment of schemes in terms of patient experience, safety and clinical outcomes. The Board of Directors should ensure an appropriate balance of in-year reporting over both quality impact and financial CIP performance.

5.9 Is a QIA Required?

5.9.1 A Project Initiation Document (PID) including QIA section must be completed for all CIP schemes and QI projects *that affect patients or service users or workforce*. Schemes or projects that do not have patient, service user or workforce impact do not need a QIA review**.**

5.9.2 If it is deemed that the scheme or project has neither patient/service user impact nor workforce impact e.g. the sale of land, change of transport contract provider, a QIA is not required. Sufficient detail should be documented to validate the decision made within CIP documentation. The QIA Review Group may request further details to confirm the validity of this decision.

5.9.3 NB. Vacancy factor only requires a QIA review where the decision to keep posts vacant is an active decision. Delays in recruitment arising from process or personnel issues do not require QIA. However the use of vacancy factor to deliver CIP will be considered in our assessment of the overall CIP burden.

5.9.4 CIP schemes or QI projects requiring a QIA review should adhere to the QIA Flowchart (Appendix 1)

5.10 Completing a QIA

5.10.1 A QIA is a risk assessment relating to patients or service users and must include:

- The impact (positive and negative) of the scheme on each of the following domains:
  - Patient safety
  - Clinical effectiveness
  - Patient experience
- How this will be reported and monitored
- For negative impacts, the current controls in place as well as mitigation that will be used to reduce the risk

5.10.2 The Trust recognises that there are a wide range of mechanisms throughout the organisation for the monitoring of quality standards and ensuring that patient care is appropriately considered as part of the decision making process. The QIA process is therefore not a single set of mechanisms as it will differ depending on the individual project (see Appendix 2). The CIP tracker acts as the key document summarising CIP progress and includes the QIA assessment and documentation that enables the capture of the processes undertaken by the relevant teams. Where QIA are required for non-CIP schemes a separate record will be kept.

5.10.3 Clear evidence is required of how clinical decision makers have been involved in the decision making process and a sign off is required from a relevant senior individual.

5.10.4 Finally a process to enable concerns to be raised in an anonymous manner will be implemented to ensure that concerns about CIP savings can be voiced.

5.11 Quality Performance Metrics

5.11.1 The QIA will identify the key benefits for service users and identify the key performance indicators that will enable the impact to be monitored and assessed. The measures for the quality domains described above must be identified and put in place to monitor the potential impact of schemes or projects on clinical services. These assurance metrics should be in addition to deliverability, financial impact and other operational related metrics (not necessarily be restricted to existing reported metrics). The QIA provides an indication of risk level and SMART indicators at the outset and risks must be reviewed and reassessed throughout the scheme or project life.

5.11.2 The project lead must identify performance metrics for the impact risks to review and report impact to the executive sponsor and QIA Review Group. Current performance metrics should be identified in the QIA e.g. patient reviews, incidents reported, PALs and complaints reviews, contact or length of stay data.

5.11.3 Potential impact details for each of the quality domains are described in Table 2.

Quality Indicator	Considerations
Patient Safety	Impact on patient safety? Impact on preventable harm? Will this impact on the organisations safeguarding duties?

	Will it affect the reliability of safety systems? How will it impact on systems related to infection control? What is the impact on clinical workforce capability care and skills?
Clinical Effectiveness	What is the potential for poor clinical outcomes, or latest technology/evidence not being taken up? Does it reduce/impact on variation in care provision? Does it affect supporting people to stay well or managing long term conditions? Does it impact on ensuring that care is delivered in most clinically and cost effective setting? Does it lead to improvements in care pathway?
Patient Experience	What is the potential for decline in experience for service users (complaints, negative feedback)? What is the impact on ability to treat patients with dignity? Are there any health and safety issues for staff? Is there a risk of a negative impact on reputation? Are there differential impacts on staff, patients or visitors with protected characteristics?

5.12 Risk Assessment

5.12.1 The risk matrix is described in Appendix 3.

5.12.2 The QIA will assess quality risks in relation to the three safety domains described above using a consistent scoring system. The scoring system for assessments is based on the Trust's risk matrix to ensure a clear link to risk registers and risk mitigation.

5.12.3 In order to achieve a risk score for each of the listed domains the author is advised to use the Trust risk scoring system as detailed within the Risk Assessment Policy (available on the internet) using the '*consequence (c) x likelihood (l)* =' matrix. Residual risk is the risk score that is estimated following implementation of the proposed mitigation or controls to reduce the risk.

5.12.4 Escalation of Risk:

- Any risk score of 12 or above must be reflected in the Directorate risk register.

- Any risk score of 15 or above i.e. red must be reflected on the Trust Risk Register

6 Roles and Responsibilities

6.1

Role	**Key Responsibilities**
Care Group / Corporate Management Team	**Project Leads** are responsible for: • undertaking quality impact assessments in line with this policy and the associated guidance; • reporting the outcome to project groups and Executive leads; • maintaining an evidence base and rationale of how and why scores were applied and any mitigating actions; • ensuring that project risk registers include any risks identified through the QIA process; • involving service users, carers in QIA where appropriate • ensuring early warning quality indicators are identified to measure any risks; • on-going monitoring of potential impacts on quality, escalation of quality and issues and reporting progress. The **Project Lead** is responsible for ensuring that the PID/QIIA process is adhered to and that paperwork is fully completed and

Role	Key Responsibilities
	signed off by the executive sponsor.
Executive Directors/ Executive Sponsors	Responsible for confirming that the QIA is accurate and ready for formal consideration by the QIA Review Team. The **Executive Sponsor** is responsible for: • ensuring that all schemes/projects have started this process prior to implementation milestones for the scheme/project; • ensuring that quality impact assessments are completed in line with this policy and the associated guidance; • signing off the PID/QIA document for CIP schemes or quality improvement projects ready for scrutiny and approval; • ratifying that the paperwork has been completed correctly and full consideration has been given to potential impacts on quality as well as how ongoing monitoring will be managed within the scheme / project; • ensuring that action is taken on the basis of quality impact assessment scores; • ensuring that quality impact assessments are reported to the Executive Team, QIA Review Group and / or Improvement Board as appropriate. Consideration must also be given to the cumulative impact across other parts of the Trust.
QIA Review Group	The **QIA Review Group** is accountable and responsible for the formal consideration (and therefore approval/rejection) of each QIA. The Chief Medical Officer and Chief Nursing Officer lead the QIA Review Group. The **QIA Review Group** will • question, probe and challenge prior to signing off approved plans; • ensure appropriate benchmarking information is made available wherever possible in order to triangulate

Role	Key Responsibilities
	assurances over viability and safety of any proposed scheme; • assess the cumulative impact on quality of CIPs and to track unintended consequences or known risks which are not being adequately mitigated. While CIPs are approved individually it is essential that the process allows for a final review of cumulative CIPs to be implemented in any one financial year; • where appropriate, request post implementation review to ensure that lessons learned are incorporated; • provide the opportunity for several layers of clinical sign off from local clinician(s) who are required to implement the change, through directorate/divisional management; • encourage inclusive practice as a means to engage clinicians who should be encouraged to voice concerns and work with the team to identify mitigations and KPIs to provide early warning of a deterioration in quality; • ensure clear engagement with frontline staff likely to be impacted by any proposal and feedback from meetings should be adequately captured and presented as part of the triangulation of assurance; • encourage the involvement of patients/service users to help bolster the overall validity of the process; • consider if the QIA has an impact with partners across Dorset and, if so, arrange for the QIA to be taken to the Clinical Reference Group for system wide discussion More detailed terms of reference are detailed in Appendix 4
PET	The **PET** is responsible for: • overseeing the process and report as required; • the integration of QIA into the CIP process; • requiring the completion of a QIA for every CIP – not allowing consideration of the CIP until this has happened.
Quality Committee/ SRO	The **Quality Committee and SRO** is responsible for: • advising and supporting the process; • scrutinising and challenging the QIA process and outcomes for individual projects on behalf of the Board of Directors; • scrutinising the potential or actual negative impacts on quality and review seeking assurance that this policy is used consistently across the organisation; • scrutinising quarterly quality impact assessment overview reports on behalf of the Board of Directors and ensuring mitigations put in place to manage negative impacts; • supporting compliance by providing advice to CIP project

Role	Key Responsibilities
	leads on all aspects of the process (quality indicators, risk assessments); • ensuring information is provided to front line staff to report concerns about CIP schemes and their potential negative impact on quality, patient experience or safety or on staff.
Individual Staff	All **staff members** are responsible for notifying their manager of quality improvement opportunities in their area.
Board of Directors	**The Board of Directors** has corporate responsibility for ensuring that cost improvement plans and service changes are not detrimental to the quality of services. The Trust Board will receive quarterly quality impact assessment overview reports through Quality Committee. The Board of Directors will: • ensure an appropriate balance of in-year reporting over both quality impact and financial CIP performance; • ensure that a full appraisal of the quality impact assessment is completed and recorded and that arrangements are put in place to monitor schemes; • sign off a final review of the full CIP programme as part of the approval process of the annual financial plan; • ensure each CIP scheme has evidence of a comprehensive risk assessment being completed on the quality impact assessment of each individual scheme. This should include assessment of schemes in terms of patient experience, safety and clinical outcomes.

7 Training

7.1 Appropriate training and awareness of the process and documentation will be provided to relevant personnel; responsible for completing QIA forms and incorporates guidance on scoring of the associated risks and identification of appropriate assurance metrics.

8 Monitoring Compliance and Effectiveness of the Document

8.1 The Quality Committee will monitor the implementation of the policy.

9 Supporting Documents & References

9.1 National Quality Board (2012): *How to Quality Impact Assess Provider Cost Improvement Plans*

9.2 Good Practice Quality Impact Assessment, NHS Providers http://nhsproviders.org/media/1160/prepprog-good-practice-qias-2.pdf

9.3 Liverpool Community Health Independent Review; https://improvement.nhs.uk/documents/2403/LiverpoolCommunityHealth_IndependentReviewReport_V2.pdf

10 Dissemination

10.1 This document will be shared via the intranet and as part of CIP documentation.

11 Approval & Ratification

11.1 This document will be approved by Quality Committee

12 Review

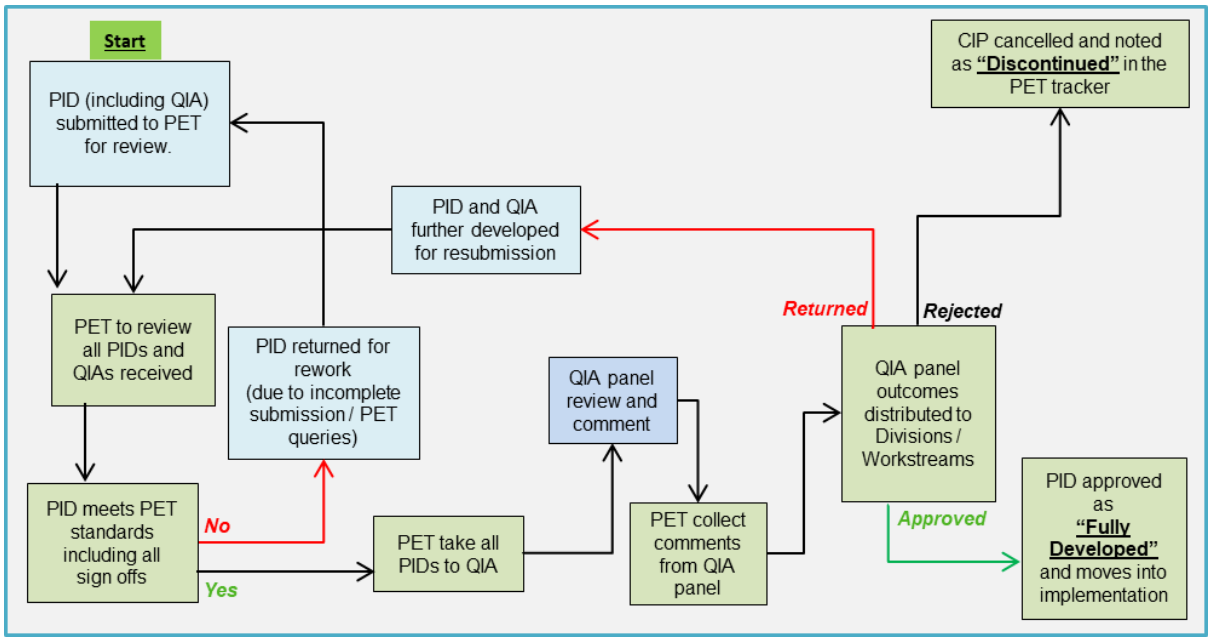
12.1 All documents must be reviewed every three years or earlier if appropriate.

13 Equality Impact Assessment

1. Title of document	**Quality Impact Assessment Policy**	
2. Date of EIA	December-21	
3. Date for review	December-22	
4. Directorate/Specialty	All	
5. Does the document/service affect one group less or more favorably than another on the basis of:		
	Yes/No	**Rationale**
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	N	Policy applies equally to all decision making and focuses on ensuring the retention of quality of service which ensures equality
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	N	As above
• Gender reassignment – the process of transitioning from one gender to another.	N	As above
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	N	As above
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.	N	As above
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	N	As above
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	N	As above
• Sex – a man or a woman.	N	As above

• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	N	As above
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	As above
8. If the answers to any of the above questions is 'yes' then:	**Yes**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.		
Adjust the policy to remove disadvantage identified or better promote equality.		

Appendix 1: QIA Flowchart



Appendix 2: QIA Processes

We recognise a wide range of options and approaches to assess the quality of decisions exist and accept these as an appropriate approach as long as they are documented appropriately:

Products and processes

- Procurement processes include assessment for the safety and clinical appropriateness of the products being sourced (inter/national safety standards for clinical products support this process)
- Medical Devices Group supports the review of the introduction of new processes and equipment

Estates and Service changes

- Clinical Assurance Group reviews major pathway and estate changes
- Transformation and Care Group Review Boards act as the key decision makers on major changes to services. They also act as a key place to review the performance and impact of changes

Skill Mix

- Ward template reviews are regular assessment of the required nursing staffing for wards; these act as a QIA process as they informed by safe staffing guidance and are signed off by senior nurses
- Other task and finish groups may exist to determine staffing levels; changes form these groups could be submitted for review

This list is not comprehensive but acts as an outline of existing processes that are suitable for QIA; where there is any uncertainty individuals should contact the Head of Productivity and Efficiency for clarification.

Appendix 3: Risk Assessment Matrix

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Very low
4 - 6	Low
8 - 12	Moderate
15 - 25	High

CIP Quality Impact Assessment Review Group
Terms of Reference

1. Purpose of The Group

1.1. This document establishes the Terms of Reference for the Group and its members.

1.2. The Group is established as part of the governance framework for Quality Performance Management to provide assurance to the Trust Board of the approval and on-going monitoring of patient safety and quality risks of all Trust cost improvement plans. (CIPs)

2. Responsibilities

2.1. To agree a robust quality and patient safety assessment process for the Trust's CIP programme and enforce this process within the Trust.

2.2. To define and agree the CIP quality and patient safety impact assessment documentation and processes updating as necessary and adhering to national guidance or best practice as issued.

2.3. To agree the CIP quality information and format to be provided to the Trust's Quality Committee and/or Trust Board for sharing internally or externally.

2.4. To review all Trust CIPs quality impact assessment and project documentation and monitor identified CIP quality risks post implementation at agreed intervals.

2.5. To challenge each CIP scheme, ensuring all risks have been considered and mitigated, and to agree the level of risk allocated by the Directorate or Care Group.

2.6. To review completed KPI monitoring information, baseline indicators and trigger points (quality indicators) escalating any concerns back through the Care Groups for further action.

2.7. To review all CIPs with or without quality and patient safety risks confirming status allocated.

2.8. To review requested CIP Post Implementation Quality Reports where necessary for identified CIPs as required, escalating any concerns back through the Care Groups for further action.

2.9. To formally review each CIP scheme, applying the appropriate RAG status and approve or reject as appropriate.

2.10. To confirm the Trust's governance framework is in place for future sustainability of this meeting, its purpose and outputs.

2.11. To consider and monitor strategic and cross-cutting issues, which may affect the wider organisation or health economy.

2.12. To receive the CIP Quality Assurance RAG status for information.

3. Membership

3.1. The Group will ask any relevant individuals and stakeholders to attend meetings to assist with discussions/reviews on any particular CIP quality impact assessment review.

3.2. The members of The Group and their roles are as follows:

Title	Named Person	Specific Group Role
Chief Nursing Officer	Paula Shobbrook	Chair
Chief Medical Officer	Alyson O'Donnell	Deputy Chair
Head of Productivity and Efficiency	Helen Rushforth	CIP QIA Lead
Associate Director of Quality Governance & Risk	Joanne Sims	Group Member

4. Attendance

Meetings of the group can be virtual or in person and require all three staff (or an appropriate deputy) to be available. Where necessary additional expertise can be sought via the Director of HR, Finance Business Partner or a Non-Executive Director.

5. Frequency of Meetings

5.1. The Group will meet virtually or in person on a monthly basis as schemes are presented by operational areas. If a significant risk or issue is identified the Chair will convene a meeting for discussion. Where no new schemes or issues have arisen a decision can be made to cancel the meeting.

5.2. The Chair may convene additional meetings, to be attended by all or part of The Group as deemed necessary. (Meetings must be quorate)

6. Access to Records

6.1. The Group will call for any documents or records to assist it with its discussions on any particular matter, although the required documents for presentation as described in the wider CIP governance will be tabled.

7. Conflicts of Interest

7.1. The group members and other attendees should declare any conflicts of interest relating to matters being discussed or reviewed by the group and, where necessary, withdraw from the relevant agenda item/s.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.6

Subject:	SIRO/Information Governance Annual Report

Prepared by:	Camilla Axtell, Information Governance Manager/DPO
Presented by:	Peter Gill, Chief Informatics Officer

Purpose of paper:	For noting
Background:	Annual update from IG Steering Group, which is a sub-group of the Audit Committee. The report only covers activities for UHD.
Key points for members:	• DSP Toolkit will not compliant at June deadline – action plan to be submitted. • Support for completion/prioritisation of Information Assurance work required Trust-wide. • Improving FOI compliance levels, but still work to do (target set by ICO is 90% compliance).
Options and decisions required:	Note for information.
Recommendations:	Noting.
Next steps:	For noting.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	n/a
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
IG Steering Group	June 2022
Audit Committee	19 May 2022

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST
AUDIT COMMITTEE

Meeting Date: May 2022

INFORMATION GOVERNANCE (IG) ANNUAL REPORT

1. Overview

The aim of imbedding good Information Governance practice throughout the Trust is to provide assurance to patients and to the Board that information is managed in a legally compliant fashion. This has remained a priority for the Trust during 2021/22.

The single IG department was formed in September 2020 and reached its full complement of staff in May 2022. Extensive work has been undertaken during the last year to understand and appraise the responsibilities of both previous IG functions, taking a “best of breed” approach in terms of aligning policy and procedure.

The events of the last two years – specifically the COVID-19 pandemic and creation of University Hospitals Dorset – have conspired to make this an extremely busy and challenging year for the Information Governance department, as work is undertaken to support healthcare services to be compliant and safe by keeping information confidential and secure.

It is hoped that the ever-increasing national focus on Information Governance will prove to be positive for the Trust in terms of continuing to push this improvement agenda forwards.

2. Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSP Toolkit) is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital annually. The purpose of the DSP Toolkit is to assure an organisation’s IG practices through the provision of evidence around 10 Data Security Standards, each of which has numerous mandatory individual requirements, known as “assertions”. This is the most significant single piece of work regularly undertaken by the Information Governance department. As well as submission to NHS Digital, compliance also forms an aspect of the contract with commissioners.

The DSP Toolkit sets the standard for cyber and data security for healthcare organisations, placing a significant focus on assuring against legislation as well as modern threats such as cyber-attacks. Most of the assurance required falls under the remit of IG and IT Security teams. Several elements also require input from the wider organisation – further information is provided in section 3.

The DSP Toolkit sets out the standards that organisations are required to meet with an expectation that this will be an ongoing journey towards compliance. The tenets of good

Information Governance can be built around the audit; however, the audit does not cover the full breadth of the IG agenda and therefore additional assurance work is necessary.

Whereas historically the deadline for DSP Toolkit submission has been at the end of March, NHS Digital postponed this to 30th June during the COVID-19 pandemic. It has been confirmed that this will remain the case henceforth, and therefore a "DSP Toolkit year" will run from 1st July to 30th June.

At date of writing, the Trust is unlikely to be able to submit a compliant DSP Toolkit by the end of June. To date, evidence has been provided to satisfy 90 out of 110 mandatory evidence items. Whilst some of the remaining 20 items are straightforward and will be completed by the deadline, others are wide-ranging and will require support from various areas of the Trust, including clinical areas, to meet the requirement. Areas requiring further work include the proactive audit of user account permissions and removal of unnecessary permissions for IT systems used across the Trust, "whitelisting" of applications that can be downloaded to Trust IT devices, risk assessment and removal of unsupported software, and the requirement for 95% of all staff to be compliant with their annual IG training in year.

The nature of the audit is that all mandatory assertions must be met to achieve a status of "Standards Met". Where all standards cannot be met, an action plan will be formulated to address any remaining assertions; the plan will be submitted to NHS Digital and the Trust's status being updated to "Approaching Standards" pending completion of that action plan.

A summary of compliance against the Data Security Standards, as currently stands, is provided at Appendix A.

3. Information Asset Assurance

Substantial importance is placed on the effective management of the vast amount of digital information held across the Trust. This is a key part of compliance with the DSP Toolkit, but this is also a matter of best practice.

A significant portion of the DSP Toolkit audit is underpinned by work associated with information risk assurance. This involves the identification of the Trust's key information systems (known as information assets), the designation of a senior person who is responsible for each system (known as an Information Asset Owner/IAO), and ensuring that each of these systems has in place such measures as appropriate contract clauses, adequate access controls, regular risk assessments and suitable business continuity plans, and to ensure that any information which is transferred into or out of the Trust through this system is risk assessed and appropriately protected. IAOs are supported in these tasks by Information Asset Administrators/IAAs. This work is essential to ensure the continuous provision of effective care and to ensure that any risks to the integrity and availability of critical information are mitigated as far as is possible.

The IAOs co-operation is critical to achieving compliance with he DSP Toolkit, as they take responsibility for providing the required assurance within each separate area of the Trust, meaning that the level of assurance provided within the DSP Toolkit submission covers the whole organisation rather than selected areas. These members of staff are directed by the Information Governance Manager under the jurisdiction of the Chief Informatics Officer/SIRO, and compliance amongst IAOs is routinely monitored through IG Steering Group.

In May 2021 the Trust rolled out its new in-house built Information Asset Register, with role-specific training offered to all IAOs and IAAs. This system enables IAOs to manage their own assets and guides them in providing the assurance required. This will be a key tool for the Trust going forwards, as it also fulfils the role of the Record of Processing Activities required by Article 30 of the UK General Data Protection Regulation.

The below table shows the number of Information Assets currently recorded by Care Group/area.

	Number of Information Assets	Number of IAOs	Number of IAAs
Surgical	27	22	27
Medical	62	34	48
Specialties	92	40	68
Corporate	80	41	69
Operations/Facilities	11	8	11
TOTAL	**272**	**145**	**223**

The work that has been undertaken during the last few years to ensure that the tasks required to be completed by IAOs are started and seen through to completion or maintained year on year has been reinvigorated through the introduction of the new IAR and delivery of refresher training to IAOs and IAAs. The Trust must continue to maintain the traction that is has gathered on this work in order to firmly imbed the concepts as "business as usual" – this must be seen as an ongoing assurance project in order to be successful.

4. Freedom of Information

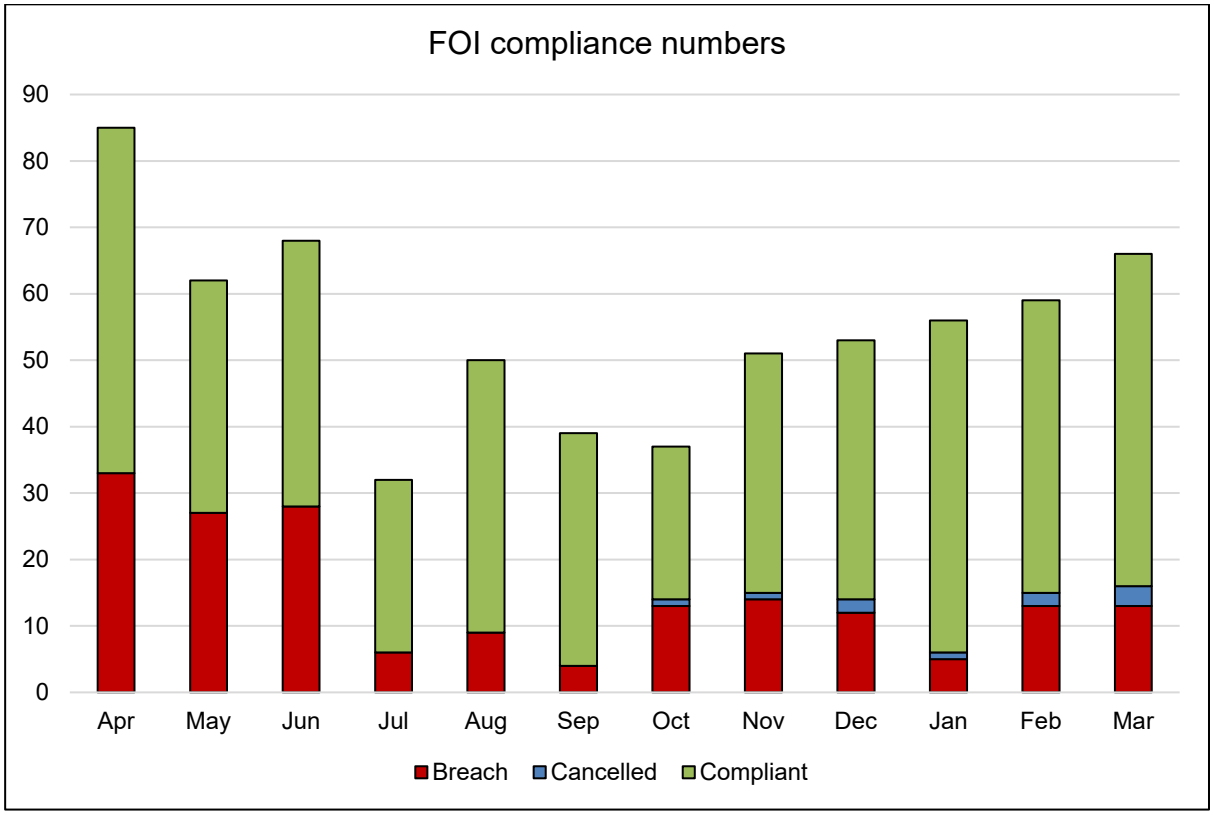
In spite of the well-documented pressures that the NHS has been under in the last two years, the number of FOI requests received has not diminished.

Compliance with the statutory time limit imposed by the FOIA remains removed from the 90% compliance target imposed by the Information Commissioner's Office (ICO); however, an improvement of compliance levels can be observed in the table and chart below. The number of breaches seen generally remains indicative of the large number of requests received, and the increased complexity of these requests which can require a significant amount of work to locate the information requested. Additionally, this can also be attributed to the difficulty of obtaining full and timely responses from staff who are managing competing priorities, and the Trust's position that critical reporting that is key to patient care and managing the financial affairs of the Trust should take priority over handling FOI requests. Further complexity has been introduced with personnel changes throughout the Trust, increasing the challenge of locating information.

The ICO will monitor selected organisations to review their performance in adhering to the Freedom of Information Act, targeting those authorities which repeatedly fail to respond to at least 90% of FOI requests received within the appropriate timescales. Monitoring may be a precursor to further action if an authority is unable to demonstrate an improvement. Further action could include the Trust having to sign an undertaking to improve its practices, an enforcement notice, reports to Parliament, or prosecution.

FOI compliance will continue to be monitored throughout 2022/23 through the Information Governance Steering Group and Audit Committee. Compliance is also included in the monthly Informatics Performance Report, and performance is actively monitored within directorates which received a significant portion of the requests.

	TOTAL	% In time	% Breach
April '21	85	61%	39%
May '21	62	56%	44%
June '21	68	59%	41%
July '21	32	81%	19%
August '21	50	82%	18%
September '21	39	90%	10%
October '21	36	64%	36%
November '21	50	72%	28%
December '21	51	76%	24%
January '22	55	91%	9%
February '22	57	77%	23%
March '22	63	79%	21%
TOTAL	**648**	**73%**	**27%**



5. IG Training

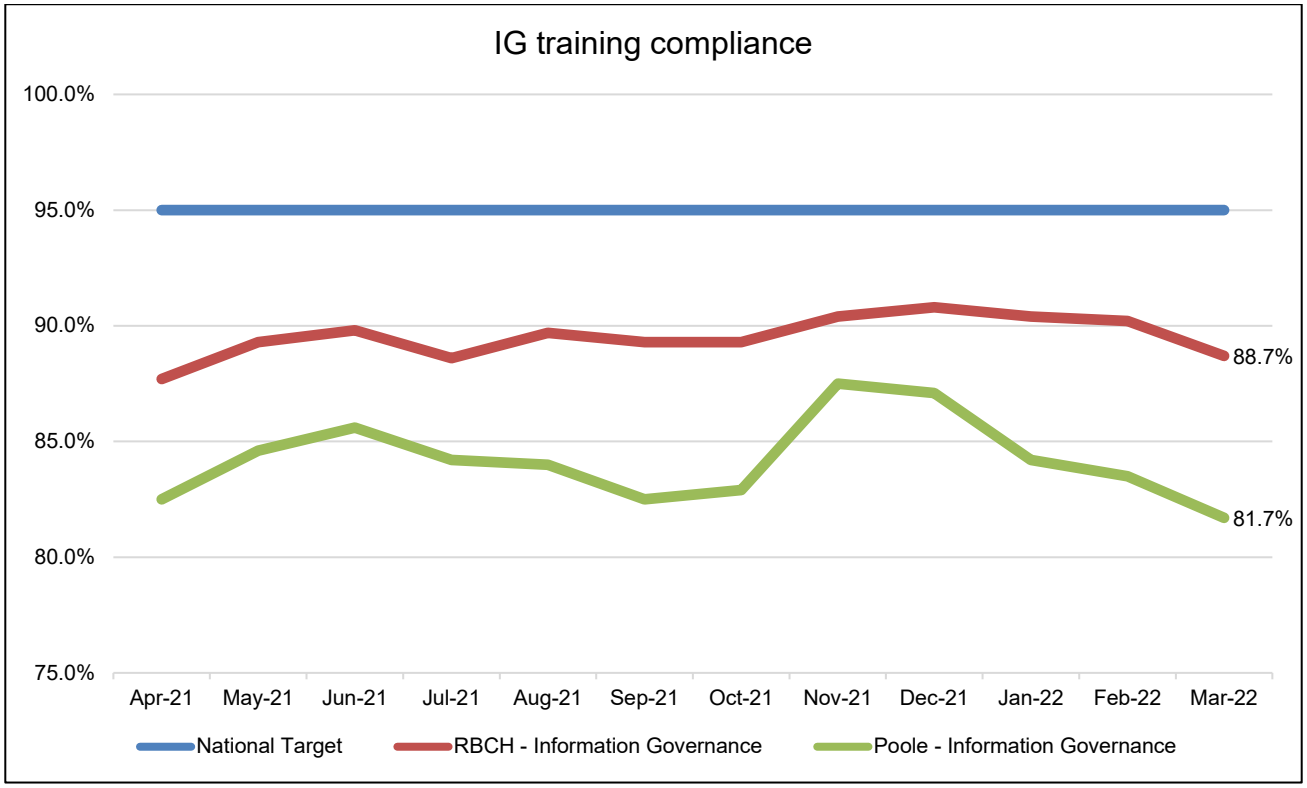
Information Governance training compliance has remained relatively consistent during last year, which is positive given that it is the only annually-updated competency on the BEAT VLE. However, the DSP Toolkit explicitly states the target required; this is reflected in assertion 3.2.1:

> *Have at least 95% of all staff, completed their annual Data Security awareness training in the period 1 July to 30 June?*

NHS Digital have confirmed that this target can be met at any point in the prescribed 12-month window.

An automated e-mail reminder is issued, via the BEAT VLE, to staff who are not compliant with their IG training, with additional emails being sent in the month prior to compliance lapsing. In support of this, a concerted campaign of chasing individuals staff members who remained non-compliant via weekly emails to GDOs was implemented in the latter half of 2021 as part of the 2020/21 DSP Toolkit action plan. Unfortunately, this did not yield the results required. Ahead of the DSP Toolkit deadline in June, a decision will be taken as to whether IG training compliance is to be noted as an organisational priority.

At present, IG Training is completed using the “Data Security Awareness Training Level 1” e-learning programme from eLearning for Healthcare. This is delivered locally to staff through the BEAT VLE, with a small number of face-to-face training sessions also being delivered in some areas. In the future, the Trust will look at bringing the creation of the e-learning content back in house in order to exercise greater control over this.



6. Incidents

Since April 2021, the Trust has been using a singular methodology of reporting IG incidents; this comprehensive approach means that many incidents are captured which may have an IG element to them, but which may not be considered exclusively IG incidents.

Once reviewed, these incidents are divided into one of three categories – Confidentiality, Integrity or Availability. Known as the "CIA Triad", these are the three high-level types of breaches as defined in by European guidance on personal data breach notification. The table below indicates the breakdown of incidents by these categories.

Under the UK General Data Protection Regulation and Data Protection Act 2018, the Trust has statutory obligations to report the most serious breaches within 78 hours and to inform data subjects affected by these breaches. This legislation introduces significantly increased financial penalties for a wider range of breaches of the legislation. Successful completion of and compliance with the DSP Toolkit enables the Trust to comply with some of the requirements of the updated legislation; however it remains essential to ensure that work streams which are key to maintaining compliance with data protection legislation, such as data flow mapping and the completion of data protection impact assessments, are supported to be considered as a "business as usual" processes.

During this period, the Trust has reported one serious incident to the ICO. A skip containing paperwork (including confidential medical records due for shredding) was broken into. Upon investigation it was thought to be extremely unlikely any confidential information was reviewed or removed. The ICO confirmed that the mitigating actions taken by the Trust were appropriate, and confirmed no further action was required.

Incidents	**TOTAL**	Confidentiality	Integrity	Availability
April '21	**29**	13	11	5
May '21	**47**	21	16	10
June '21	**36**	19	11	6
July '21	**49**	13	25	11
August '21	**47**	16	25	6
September '21	**52***	20*	27	5
October '21	**54**	22	25	7
November '21	**45**	20	22	3
December '21	**30**	13	11	6
January '22	**35**	19	11	5
February '22	**33**	18	11	4
March '22	**27**	12	10	5
TOTAL	**484**	**206**	**205**	**73**

* includes one serious incident reported to the ICO.

Conclusion

Progress is being made to embed changes to legislation and assurance mechanisms required across the new organisation; however, there is still a lot of work to do.

It must be recognised that the assurance work undertaken through the DSP Toolkit is ongoing and requires continual update and maintenance to ensure that compliance with the relevant legislation and national standards can be sustained. While the initial drive to begin to imbed this initiative is perhaps the most difficult, it is essential that this momentum is sustained to avoid a retrograde slump, negating any achievements realised. Support is required from the organisation as a whole to ensure that this work is given the necessary priority on an ongoing basis.

During 2022/23, the priority will be to improve upon the current level of compliance with FOI and information risk assurance work, as well as the successful completion of the DSP Toolkit action plan.

Camilla Axtell
Information Governance Manager and Data Protection Officer
11 May 2022

Appendix A – Data Security and Protection Toolkit scores (as of 11 May 2022)

Order	Evidence code	Assertion	Predicted Status
1		**Data Security Standard 1** All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes. Staff understand how to strike the balance between sharing and protecting information, and expertise is on hand to help them make sensible judgments. Staff are trained in the relevant pieces of legislation and periodically reminded of the consequences to patients, their employer and to themselves of mishandling personal confidential data.	
		Mandatory assertions satisfied – 2 / 4	Incomplete
2		**Data Security Standard 2** All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches. All staff understand what constitutes deliberate, negligent or complacent behaviour and the implications for their employment. They are made aware that their usage of IT systems is logged and attributable to them personally. Insecure behaviours are reported without fear of recrimination and procedures which prompt insecure workarounds are reported, with action taken.	
		Mandatory assertions satisfied – 1 / 1	Complete
3		**Data Security Standard 3** All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit. All staff complete an annual security module, linked to 'CareCERT Assurance'. The course is followed by a test, which can be re-taken unlimited times but which must ultimately be passed. Staff are supported by their organisation in understanding data security and in passing the test. The training includes a number of realistic and relevant case studies.	

	Mandatory assertions satisfied – 2 / 4	Incomplete
4	**Data Security Standard 4** Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals. The principle of 'least privilege' is applied, so that users do not have access to data they have no business need to see. Staff do not accumulate system accesses over time. User privileges are proactively managed so that there is, as far as is practicable, a forensic trail back to a specific user or user group. Where necessary, organisations will look to non-technical means of recording IT usage (e.g. sign in sheets, CCTV, correlation with other systems, shift rosters etc).	
	Mandatory assertions satisfied – 2 / 5	Incomplete
5	**Data Security Standard 5** Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security. Past security breaches and near misses are recorded and used to inform periodic workshops to identify and manage problem processes. User representation is crucial. This should be a candid look at where high risk behaviours are most commonly seen, followed by actions to address these issues while not making life more painful for users (as pain will often be the root cause of an insecure workaround). If security feels like a hassle, it's not being done properly.	
	Mandatory assertions satisfied – 1 / 1	Complete
6	**Data Security Standard 6** Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection. All staff are trained in how to report an incident, and appreciation is expressed when incidents are reported. Sitting on an incident, rather than reporting it promptly, faces harsh sanctions. [The Board] understands that it is ultimately accountable for the impact of security incidents, and bear the responsibility for making staff aware of their responsibilities to report upwards. Basic safeguards are in place to prevent users from unsafe internet use. Anti-virus, anti-spam filters and basic firewall protections are deployed to protect users from basic internet-borne threats.	

	Mandatory assertions satisfied – 1 / 3	Incomplete
7	**Data Security Standard 7** A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management. A business continuity exercise is run every year as a minimum, with guidance and templates available from [CareCERT Assurance]. Those in key roles will receive dedicated training so as to make judicious use of the available materials, ensuring that planning is modelled around the needs of their own business. There should be a clear focus on enabling senior management to make good decisions, and this requires genuine understanding of the topic, as well as the good use of plain English.	
	Mandatory assertions satisfied – 2 / 3	Incomplete
8	**Data Security Standard 8** No unsupported operating systems, software or internet browsers are used within the IT estate. Guidance and support is available from CareCERT Assurance to ensure risk owners understand how to prioritise their vulnerabilities. There is a clear recognition that not all unsupported systems can be upgraded and that financial and other constraints should drive intelligent discussion around priorities. Value for money is of utmost importance, as is the need to understand the risks posed by those systems which cannot be upgraded. It's about demonstrating that analysis has been done and informed decisions were made.	
	Mandatory assertions satisfied – 2 / 4	Incomplete
9	**Data Security Standard 9** A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually. [CareCERT Assurance] assists risk owners in understanding which national frameworks do what, and which components are intended to achieve which outcomes. There is a clear understanding that organisations can tackle the NDG Standards in whichever order they choose, and that the emphasis is on progress from their own starting points.	
	Mandatory assertions satisfied – 3 / 6	Incomplete

10	**Data Security Standard 10** IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards. IT suppliers understand their obligations as data processors under the GDPR, and the necessity to educate and inform customers, working with them to combine security and usability in systems. IT suppliers typically service large numbers of similar organisations and as such represent a large proportion of the overall 'attack surface'. Consequently, their duty to robust risk management is vital and should be built into contracts as a matter of course. It is incumbent on suppliers of all IT systems to ensure their software runs on supported operating systems and is compatible with supported internet browsers and plug-ins.	
	Mandatory assertions satisfied – 1 / 2	Incomplete

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.7

Subject:	Register of Use of the Seal 2021/22

Prepared by:	Sarah Locke, Deputy Company Secretary
Presented by:	Yasmin Dossabhoy, Associate Director of Corporate Governance

Purpose of paper:	To provide the annual report on the use of the Trust seal.
Background:	The University Hospitals Dorset NHS Foundation Trust Constitution states that an entry of every sealing shall be made and numbered consecutively by the Company Secretary. A report of all sealing shall be made to the Board of Directors annually.
Key points for Board members:	The seal was used on eight occasions during the period of 1 April 2021 to 31 March 2022.
Options and decisions required:	No decision required.
Recommendations:	To note the seal of documents register.
Next steps:	Each use of the seal will continue to be recorded and a register of use of the seal for 2022/23 will be provided to the Board in 2023.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	To be a well-governed and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.
BAF/Corporate Risk Register: (if applicable)	N/A
CQC Reference:	Well-Led

Committees/Meetings at which the paper has been submitted:	**Date**

University Hospitals Dorset NHS Foundation Trust

Register of Use of Seal (2021/22) – 01 April 2021 to 31 March 2022

	Company	Transaction	Authorised By	Witnessed By	Date
8	Bio-Rad Laboratories Limited	Pathology Managed Services for Lot 4 Transfusion	Peter Gill, Chief Informatics Officer	Karen Allman, Chief People Officer	20 April 2021
9	Roche Diagnostics Limited	Pathology Managed Services for Lots 1, 2 and 6	Peter Gill, Chief Informatics Officer	Karen Allman, Chief People Officer	20 April 2021
10	Bio-Rad Laboratories Limited	Lot 4 Transfusion	Paula Shobbrook, Chief Nursing Officer	Peter Gill, Chief Informatics Officer	04 May 2021
11	Westmade Limited Netherhampton, Salisbury, SP2 8PU	Atrium Decants	Debbie Fleming, Chief Executive Officer	Alyson O'Donnell, Chief Medical Officer	17 May 2021
12	Siemens Healthcare Limited	Gammas Cameras	Peter Gill, Chief Informatics Officer	Richard Renaut, Chief Strategy and Transformation Officer	20 July 2021
13	Stago UK Limited	Pathology Managed Services Lot 3 Coagulation	Debbie Fleming, Chief Executive Officer	Richard Renaut, Chief Strategy and Transformation Officer	31 August 2021
14	Charlotte Anne Townshend DL James Reginald Townshend Ilchester Trustee Company Limited	Yeomans Industrial Park Lead	Debbie Fleming, Chief Executive Officer	Mark Mould, Chief Operating Officer	18 October 2021
15	Integrated Health Projects	P22 Forms of Agreement (stage 4)	Paula Shobbrook, Chief Nursing Officer	Karen Allman, Chief People Officer	08 March 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.8

Subject:	Gifts and Hospitality Register

Prepared by:	Ewan Gauvin, Corporate Governance Manager
Presented by:	Yasmin Dossabhoy, Associate Director of Corporate Governance

Purpose of paper:	To note the Trust's Register of Gifts & Hospitality.
Background:	The "Managing Conflicts of Interest" Policy specifies that the register of interests should be reviewed by the Audit Committee annually.
Key points for Board members:	The paper attached is the Register of Gifts & Hospitality 21/22.
Options and decisions required:	The Board is asked to note the Gifts and Hospitality Register.
Recommendations:	To note the Gifts and Hospitality Register.
Next steps:	The Gifts and Hospitality Register will be published on the Trust website.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	To be a well-governed and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well-Led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	19 May 2022

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

REGISTER OF GIFTS AND HOSPITALITY RECEIVED BY STAFF

Staff at University Hospitals Dorset NHS Foundation Trust declared receiving the following gifts and hospitality in the period of 1 April 2021 to 31 March 2022:

TITLE	GIFTS AND HOSPITALITY REGISTER
Secretary, Cardiac Rehabilitation	• Lunch provided for team meeting - Offered by: AstraZeneca - Value: £60
Consultant Haematologist	• Sponsorship to attend virtual European Haematology Association Annual Education Meeting - Offered by: Novartis - Value: £250 - Approved by line manager • Payment for Takeda Advisory Board - Offered by: Takeda - Value: £1,000 - Approved by line manager • Payment for teaching session - Offered by: Jazz Pharmaceuticals - Value: £1,200 - Approved by line manager
Consultant Cardiologist	• Sponsorship to attend virtual European Society of Cardiology Conference - Offered by: Daiichi Sankyo - Value: Nil - Approved by line manager
Clinical Lead, Thoracic	• Sponsorship for registration to Primary Care Respiratory Society and Virtual Conference - Offered by: Chiesi Pharmaceuticals - Value: £65 - Approved by line manager • Sponsorship for registration to Network Conference - Offered by: Chiesi Pharmaceuticals - Value: Nil - Approved by line manager
Consultant Gastroenterologist	• Payment to delivery educational talk - Offered by: Janssen Pharmaceuticals - Value: £450 - Approved by line manager

TITLE	GIFTS AND HOSPITALITY REGISTER
Consultant Rheumatologist	• Sponsorship to attend "Evolution in Rheumatology" meeting October 2021 - Offered by: UCB Pharmaceuticals - Value: Exact value unknown; consisted of travel, overnight accommodation and meals - Approved by line manager • Sponsorship to attend British Society for Rheumatology Conference Glasgow, 25-27 April 2022 - Offered by: Novartis - Value: Exact value unknown; consisted of registration, travel and accommodation - Approved by line manager • Sponsorship to attend EULAR 2022 eCongress - Offered by: UCB Pharmaceuticals - Value: £224 - Approved by line manager
Consultant Gastroenterologist	• Invitation to Virtual ECCO Annual Congress 2021 - Offered by: Janssen - Value: £250
Consultant Radiologist	• Heartflow Cardiology Meal - Offered by: Heartflow - Value: £50 - Approved by line manager
Consultant Cardiologist	• Sponsorship to attend Electrical Management of Cardiac Diseases Course in Bordeaux, September 2021 - Offered by: Boston Scientific - Value: Exact value unknown; consisted of travel, accommodation and meals - Approved by line manager
Physiotherapist	• Cash included in "thank you" card - Offered by: Patient - Value: £50 - Approved by line manager, added to staff wellbeing fund
Consultant Radiologist	• Dinner as part of regional training event - Offered by: Boston Scientific - Value: £30 • Dinner as part of regional training event - Offered by: Boston Scientific - Value: £30

TITLE	GIFTS AND HOSPITALITY REGISTER
Consultant Rheumatologist	• Payment to chair a clinical meeting - Offered by: Galapagos Biotech - Value: £998.75 - Approved by line manager
Orthopaedic Consultant	• Dinner and meeting with knee consultants - Offered by: Zimmer Biomet - Value: £40 - Approved by line manager
Consultant Cardiologist	• Sponsored Heartflow meeting - Offered by: Heartflow - Value: Exact value unknown; consisted of dinner - Approved by line manager • Sponsored meeting “Exploring alternative solutions to ongoing problems in cholesterol management” - Offered by: Daiichi Sankyo - Value: Exact value unknown; consisted of refreshments - Approved by line manager • Sponsored South Coast Interventional Group meeting - Offered by: Terumo - Value: Exact value unknown; consisted of accommodation for one night and meals - Approved by line manager • Sponsored meeting “The cardiovascular challenge: Adopting new strategies and approaches in stroke prevention” - Offered by: Daiichi Sankyo - Value: Exact value unknown, consisted of dinner - Approved by line manager
Orthopaedic Consultant	• Reimbursement of expenses incurred as an examiner for RCS - Offered by: Royal College of Surgeons (England) - Value: £460.07 - Approved by line manager
Consultant Radiologist	• Sponsored Heartflow lectures - Offered by: Heartflow - Value: £50 - Approved by line manager
Consultant Geriatrician	• Payment to support Primary Care Network meeting “Frailty, Malnutrition and Sarcopenia” - Offered by: Abbott Nutrition - Value: £1000 - Approved by line manager

University Hospitals Dorset
NHS Foundation Trust

TITLE	GIFTS AND HOSPITALITY REGISTER
Professor of Orthopaedics	• Christmas Hamper, December 2021 - Offered by: Nuffield Hospital, Bournemouth - Value: Market value - Approved by line manager • Entry to England rugby match, February 2022 - Offered by: Nuffield Hospital, Bournemouth - Value: Market value - Approved by line manager

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.9

Subject:	Register of Interests

Prepared by:	Ewan Gauvin, Corporate Governance Manager
Presented by:	Yasmin Dossabhoy, Associate Director of Corporate Governance

Purpose of paper:	To note the Register of Interests prior to publication on the Trust website.
Background:	The "Managing Conflicts of Interest" Policy specifies that the register of interests should be should be reviewed by the Audit Committee annually.
Key points for Board members:	Included in the report are: • Register of Staff Interests 21/22 • Register of Board of Directors Interests as at 31 March 2022
Options and decisions required:	The Board is asked to note the register of staff interests and to approve the Register of Board of Directors Interests.
Recommendations:	To approve the Board of Directors Register of Interests.
Next steps:	The Register of Interests will be published on the Trust website.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	To be a well-governed and well-managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well-Led

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	19 May 2022

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

REGISTER OF STAFF INTERESTS

Staff at University Hospitals Dorset NHS Foundation Trust declared the following interests in the period of 1 April 2021 to 31 March 2022:

TITLE	REGISTER OF INTERESTS
Consultant Urologist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole - Bournemouth Private Clinic
Consultant Vascular Surgeon	• Private Practice: - Nuffield Hospital, Bournemouth
Emergency Medicine Consultant	• Outside Employment: - Clinical Care Doctor, Dorset & Somerset Air Ambulance
Consultant Dermatologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic - Southface Medical Clinic
Consultant Anaesthetist	• Private Practice: - Harbour Hospital, Poole - Nuffield Hospital, Bournemouth
Consultant Radiologist	• Private work undertaken on Poole site • Additional NHS reporting of PET-CT outside of contracted hours, invoiced to Alliance Medical.
Consultant Surgeon	• Private Practice: - Harbour Hospital, Poole - Nuffield Hospital, Bournemouth
Consultant Rheumatologist	• Private Practice: - Harbour Hospital, Poole
Consultant Cardiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Dorset Heart Clinic
Consultant Surgeon	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Anaesthetist	• Private Practice: - Bournemouth Private Clinic

TITLE	REGISTER OF INTERESTS
Consultant Radiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole
Consultant Radiologist	• Private Practice: - Harbour Hospital, Poole
Consultant Radiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole
Consultant Radiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole - TMC Teleradiology
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole - Portland Clinical • Outside Employment: - Bank Vaccinator, Dorset HealthCare University NHS FT
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole - Wimborne Hospital - Lymington Hospital
Consultant Ophthalmologist	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Cardiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Dorset Heart Clinic
Consultant Radiologist	• Outside Employment: - Bank Consultant Radiologist, Isle of Wight NHS Trust
Consultant Surgeon	• Outside Employment: - Consultant Surgeon, Portland Clinical
Consultant Obstetrician	• Outside Employment: - Consultant Obstetrician, Portland Clinical
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Queen Victoria Hospital - New Forest Hospital

TITLE	REGISTER OF INTERESTS
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole
Consultant Orthopaedic Surgeon	• Educational consultancy, Zimmer Biomed • Director of LSR Medical • Member of design development team for acetabular components
Consultant Microbiologist	• Fellow, Bournemouth University
Associate Director of Estates	• Son works for company providing WIFI maintenance to residences at the Royal Bournemouth Hospital
Consultant Dermatologist	• Private Practice: - Harbour Hospital, Poole
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth, - Harbour Hospital, Poole - Lymington Hospital
Consultant Gastroenterologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic
Consultant Anaesthetist	• Private Practice: - Bournemouth Private Clinic - Dorset Heart Clinic • Outside Employment - Consultant Anaesthetist, Portland Clinical
Head of Pathology	• Director, Immunotec Ltd
Consultant Paediatrician	• Director, Doctor and Doctors Ltd
Consultant Anaesthetist	• Private Practice: - Harbour Hospital, Poole - Nuffield Hospital, Bournemouth - Lymington Hospital - Bournemouth Private Clinic
Consultant Rheumatologist	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Endocrinologist / Group Medical Director	• Director, Wessex Endocrine Solutions • Private Practice: - Nuffield Hospital, Bournemouth
Consultant Anaesthetist	• Private Practice: - Bournemouth Private Clinic

TITLE	REGISTER OF INTERESTS
Consultant Surgeon	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Radiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic
Specialty Doctor	• Medico-legal private practice
Consultant Radiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic
Consultant Obstetrician	• Private Practice: - The Clinic@78
Consultant Anaesthetist	• Private Practice: - Bournemouth Private Clinic - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole - Lymington Hospital - Wimborne Hospital
Consultant Anaesthetist	• Member of Group Anaesthetic Services LLP • Private Practice: - Nuffield Hospital, Bournemouth - Lymington Hospital - Wimborne Hospital
Consultant Ophthalmologist	• Outside Employment: - Adhoc work for Professional Support & Well-being (PSW) unit
Consultant Paediatrician	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Physician	• Associate, General Medical Council • Medical Secretary, Federation of Royal Colleges of Physicians
Consultant Cardiologist	• Private practice within Dorset HealthCare University NHS FT • Consultant and Shareholder, ECG OD / Technomed Ltd • Clinical Ambassador, NHSE&I
Consultant Urologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic
Consultant Gastroenterologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic

TITLE	REGISTER OF INTERESTS
Consultant Rheumatologist	• Private Practice: - Harbour Hospital, Poole
Consultant Urologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic
Orthopaedic Consultant	• Director of Charles Willis-Owen Ltd • Manages investment portfolio including pensions, investment trusts and venture capital trust, which include the healthcare sector • Private Practice: - Bournemouth Private Clinic - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole
Head of Charity	• Director and Shareholder, JJ Moore (Swanage) Ltd
General Manager	• Director of Pellerehealth Ltd
Consultant Radiologist	• Private work for Ltd company
Professor of Orthopaedics	• Director, RG & PR Middleton Ltd • Director, Healthdecoded Ltd • Professor of Orthopaedics, Bournemouth University • Consultancy/Royalties from Zimmer-Biomet, Stryker, Lima, Johnson and Johnson, Firstkind and Caresyntax • Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic - Harbour Hospital, Poole
Consultant Paediatrician	• Member, Joint Ambulance Liaison Committee • Member, RCPCH Emergency Standards Committee • Member, Advanced Paediatric Life Support Working Group
Orthopaedic Consultant	• Director of Blakeway & Blakeway Ltd
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole - Lymington Hospital - Wimborne Hospital • Outside Employment: - Consultant Anaesthetist, Portland Clinical - Consultant Anaesthetist, Medinet

TITLE	REGISTER OF INTERESTS
Consultant Urologist	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Radiologist	• Private Practice: - Nuffield Hospital, Bournemouth - Bournemouth Private Clinic - AECC University College - Medica Teleradiology
Consultant Radiologist	• Private Practice: - Nuffield Hospital, Bournemouth
Associate Specialist	• Outside Employment: - Evolutio Care Innovations Ltd
Consultant Neurophysiologist	• Private Practice: - Poole Hospital Private Clinic
Consultant Neurophysiologist	• Private Practice: - Dorset County Hospital NHS FT - Nuffield Hospital, Bournemouth • Outside Employment: - Bespoke Healthcare Ltd
Orthopaedic Consultant	• Private Practice: - Harbour Hospital, Poole - Nuffield Hospital, Bournemouth
Consultant Anaesthetist	• Outside Employment: - Bank Consultant Anaesthetist, Dorset Healthcare University NHS FT
Consultant in Emergency Medicine	• Outside Employment: - Médecins sans frontières (3 months per year, included in UHD contract)
Consultant Anaesthetist	• Private Practice: - Poole Hospital Private Clinic - University Hospitals Dorset Private Practice - Nuffield Hospital, Bournemouth - Circle Health, Poole
Consultant Histopathologist	• Private Practice: - Bournemouth Private Clinic
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Lyminton Hospital - Wimborne Hospital • Volunteer, Wessex Intensive Care Society

TITLE	REGISTER OF INTERESTS
Consultant Cardiologist	• Private Practice: - Dorset Heart Clinic
Consultant Colorectal Surgeon	• Private Practice: - Harbour Hospital, Poole • Outside Employment: - Portland Clinical
Specialty Registrar	• Adhoc administration for husband's business
Bank Consultant	• Private Practice: - London Diabetes Centre • Outside Employment - Self-employed consultancy / project management
Consultant Paediatrician	• Honorarium work for Health Education England
Consultant Neurologist	• Private Practice: - Harbour Hospital, Poole - Winterborne Hospital
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole - British Pregnancy Advisory Service - Wimborne Hospital - Lymington Hospital
Consultant Radiologist	• Private Practice: - Telemedicine Clinic
Consultant Microbiologist	• Outside Employment: - NHS Blood & Transplant
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Obstetrician / Group Medical Director	• Private Practice: - Harbour Hospital, Poole Hospital - Nuffield Hospital, Bournemouth
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole Hospital NHS Foundation Trust • Outside Employment: - Dorset & Somerset Air Ambulance
Orthopaedic Consultant	• Private Practice: - Nuffied Hospital, Bournemouth - Bournemouth Private Clinic - Harbour Hospital, Poole

TITLE	REGISTER OF INTERESTS
Consultant Surgeon	• Private Practice: - Nuffield Hospital, Bournemouth
Consultant Cardiologist	• Private Practice: - Dorset Heart Clinic • Director of Dorset Heart Rhythm Ltd (non-salaried)
Consultant Haematologist	• Private Practice: - Harbour Hospital, Poole - University Hospitals Dorset Private Practice
Consultant Orthopaedic Surgeon	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole
Consultant Surgeon	• Private Practice: - Harbour Hospital, Poole
Consultant Anaesthetist	• Private Practice: - Nuffield Hospital, Bournemouth
Locum A&E Doctor	• Outside Employment: - Locum A&E Doctor, Hampshire Hospitals NHS FT
Orthopaedic Consultant	• Private Practice: - Nuffield Hospital, Bournemouth - Harbour Hospital, Poole

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

REGISTER OF BOARD OF DIRECTORS' INTERESTS

The following interests, as at 31 March 2022, were declared by the Board of Directors of University Hospitals Dorset NHS Foundation Trust:

NAME AND TITLE	INTEREST REGISTER
Ms Karen Allman Chief People Officer	• None
Mr Pankaj Davé Non-Executive Director	• Royal College of Surgeons of England: Board Lay Trustee and Chair of the Audit and Risk Committee • Royal College of Surgeons observer on the board of the newly formed College of General Dentistry
Mrs Debbie Fleming OBE Chief Executive *(until 31 March 2022)*	• Director of Private Health University Hospitals Dorset Limited • Director of The Bournemouth and Poole Healthcare Trust • Trustee of The Bournemouth and Poole Healthcare Trust • Chair of the Dorset Cancer Partnership • Member of Wimborne Academy Trust
Mr Peter Gill Chief Informatics Officer	• None
Mr Philip Green Non-Executive Director & Vice Chairman *(as at 31 March 2022)* Acting Chairman *(from 1 April 2022)*	• Leeds University Business School International Research Advisory Board
Ms Fiona Hoskins Acting Chief Nursing Officer *(from 1 April 2022)*	• None
Mr John Lelliott OBE Non-Executive Director	• Non-Executive Director – Environment Agency • Non-Executive Director – Covent Garden Market Authority • Board member – The Capitals Coalition • Trustee - Centre for Sustainable Healthcare • Trustee – JTL Training • Daughter – Pharmacist • Son-in-law – Pharmacist

NAME AND TITLE	INTEREST REGISTER
Mr David Moss Chairman *(until 31 March 2022)*	• Vice-President & Trustee – Hospital Services Cricket Club
Mr Stephen Mount Non-Executive Director	• Non-Executive Director: Gama Aviation PLC
Mr Mark Mould Chief Operating Officer	• Director of Concept Works Ltd (property rental company) 50% share. • Wife owns iSkincare Ltd (Aesthetic Company) • Stepdaughter - Bank Staff • Stepdaughter - Student Nurse, Bournemouth University • Director - Private Health University Hospitals Dorset Limited • Director - The Bournemouth and Poole Healthcare Trust • Trustee - The Bournemouth and Poole Healthcare Trust
Dr Alyson O'Donnell Chief Medical Officer	• None
Mr Pete Papworth Chief Finance Officer	• Director - The Bournemouth and Poole Healthcare Trust • Director - The Private Health University Hospitals Dorset Limited • Trustee - The Bournemouth and Poole Healthcare Trust • Wife – HR Business Partner at Dorset Healthcare University NHS Foundation Trust
Mr Richard Renaut Chief Strategy and Transformation Officer	• Wife a Pharmacist • Director - The Bournemouth and Poole Healthcare Trust • Director - The Private Health University Hospitals Dorset Limited • Trustee - The Bournemouth and Poole Healthcare Trust
Prof Clifford Shearman OBE Non-Executive Director	• Independent Non-Executive Director - Spire Health Care Group PLC • Company Secretary - Wessex Medical Reporting Limited • Emeritus Professor of Vascular Surgery University of Southampton

University Hospitals Dorset
NHS Foundation Trust

NAME AND TITLE	INTEREST REGISTER
Prof Paula Shobbrook Chief Nursing Officer *(as at 31 March 2022)* Acting Chief Executive *(from 1 April 2022)*	• Husband – Managing Director and Shareholder: Albany Care (Porchester) Ltd Albany Care (Northampton) Ltd Albany Farm Care (Havant) Ltd Albany Farm Care (Oxford) Ltd Albany Farm Care (Hampshire) Ltd
Mrs Caroline Tapster CBE Non-Executive Director	• Sister-in-law employed by the Trust. • Nephew employed by the Trust

In compliance with paragraph C.1.13 of the Monitor/ NHS Improvement Code of Governance for NHS Foundation Trusts, no executive director holds more than one non-executive directorship of an NHS Foundation Trust or another organisation of comparable size and complexity.

31 March 2022

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.11

Subject:	Annual Operating Plan 2022/23 and Annual Objectives

Prepared by:	Alan Betts
Presented by:	Richard Renaut

Purpose of paper:	To request that the Trust Board **approve** the UHD Annual Operating Plan 2022/23 and to **note** the updated diagram relating to the Annual Objectives
Background:	The UHD Annual Operating Plan is part of the Dorset ICS Annual Operating Plan and has been developed over the past 3 months based upon Care Group Plans, Dorset ICS guidance and National Operational Planning guidance. A version was presented to the Trust Board on 25th April 2022. Various versions have been presented to Trust Management Group (TMG) and the Council of Governors Strategy Group throughout March and April with TMG approving the version presented on 19th April 2022. The amended sections of the annual operating plan have been included as appendix 1 and appendix 2 in this paper.
Key points for members:	Further to the annual operational plan, the following amendments have been made:- Appendix 1 – Introduction Section (Chapter 1) of the Annual Operating Plan 2022/23 Feedback from Joint Leadership Forum (JLF) indicated that the three main work programmes (emergency flow, elective recovery and workforce sustainability) are of equal importance with the underpinning theme of quality services and a well led approach. As a result of this the diagram in the chapter is being redesigned to reflect the change and the old diagram included in the chapter will be replaced once that work is complete.

	The text of the introductory chapter has been amended to reflect the JLF feedback change and a few minor word changes have been made in the Trust objectives to better link the strategic priorities and objectives to the main work programmes. The revised chapter 1 has been included in Appendix 1 of this paper. Appendix 2 – Finance Section (Chapter 7) of the Annual Operating Plan 2022/23 The finance chapter amended to reflect the final discussions around ICS Financial Framework and has been included in Appendix 2 of this paper. Minor grammatical and typographical changes have also been made throughout the plan. There have been no changes to Care Group Plans since these were presented to Trust Board on 27th April 2022.
Options and decisions required:	N/A
Recommendations:	The Trust Board **approve** the UHD Annual Operating Plan 2022/23
Next steps:	The Annual Operating Plan forms the basis of Trust work plans for the coming year and will form part of the ongoing delivery monitoring and assessment processes via the Trust accountability Framework.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	

Committees/Meetings at which the paper has been submitted:	**Date**
Council of Governors Strategy Group	2/3/2022
Trust executives Group	8/3/2022
Operational Performance Group	10/3/2022
Care Group Boards	18/3/2022
Trust Management Group	22/3/2022
Trust Management Group	19/4/2022
Trust Board	27/4/2022

University Hospitals Dorset
NHS Foundation Trust

2022/23 Operational Plan: University Hospitals Dorset NHS Foundation Trust

MASTER VERSION - Version 3.2

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1. Introduction - Our Priorities

University Hospital Dorset's (UHD) Annual Operating Plan sets out a significant programme of work for an organisation just 18 months old. The plan sits within the Dorset Integrated Care System plans and within some of the most challenging times the NHS and Social Care have ever faced.

Our multi-year strategy is based on our mission to provide excellent healthcare and to be a great place to work, now and for future generations. We have a once in a generation opportunity to transform our services and 2022/23 will be a cruicial year to re-establish services and re-focus on delivery of excellent care.

As part of our re-focus we have identified the key drivers and areas that have greatest impact on our services. From this a programme-based approach is being developed, focussing on the three most critical areas:

- Emergency care and hospital flow
- Maximising elective care
- Investing in our workforce

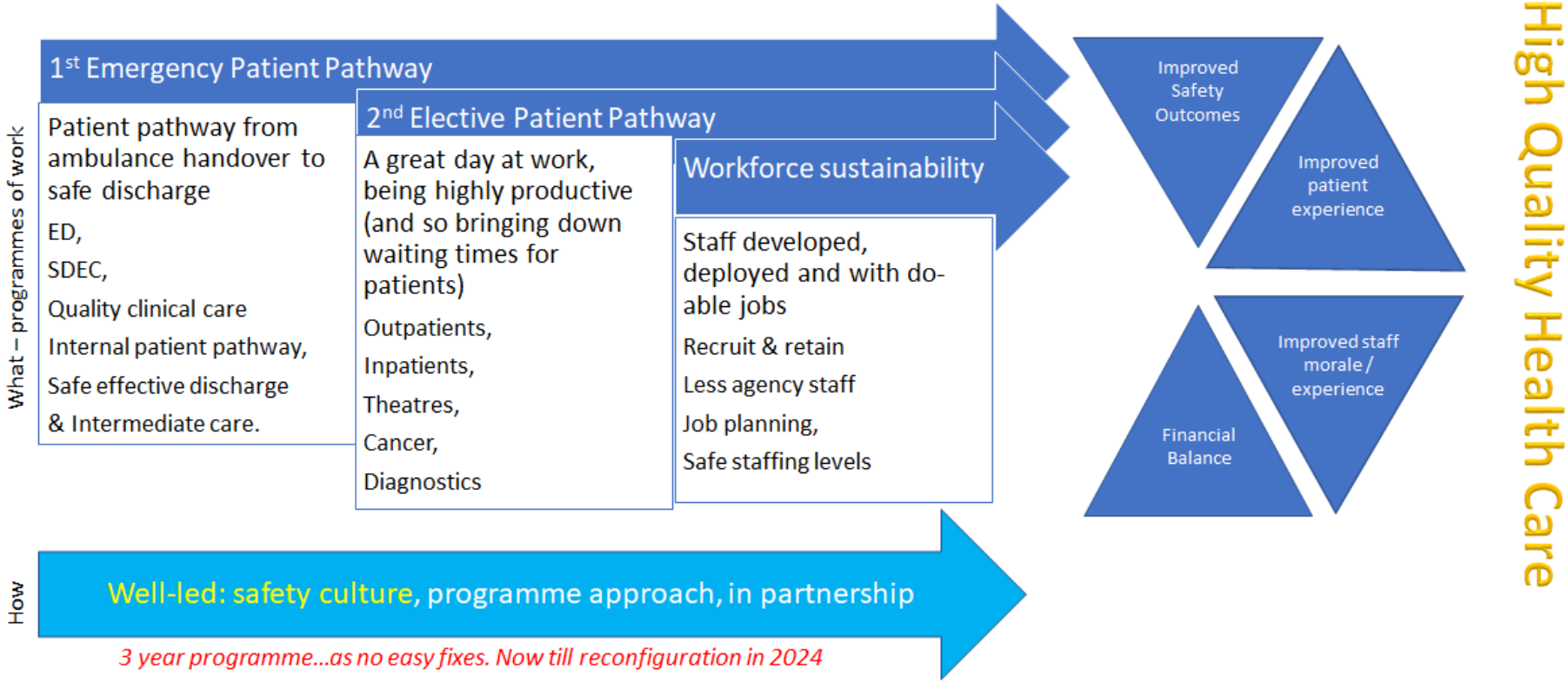
No single one of these priorities will enable us to provide great care, better outcomes for our patients, motivated teams and timely access to care on their own. Together, they unlock far wider benefits throughout our hospitals and for all our staff and patients, and form key parts of our wider annual objectives for 22/23.

For example, improving our emergency care pathways and the experience these patients have will mean fewer elective cancellations due to overwhelming operational pressures.

Our patients rightly expect to receive timely planned care – and we all want to provide this. By maximising our teams, facilities and new technology, we can see more patients for their scheduled care, helping to see patients sooner. This priority is paramount in addressing the numbers of patients on our waiting lists as a consequence of the Covid-19 pandemic.

These achievements will mean little if our workforce is not supported to thrive, develop and grow as we bring in new talent, and keep hold on to those colleagues whose contributions are immeasurable. Our goal is to support and develop all staff in order to meet our priorities for our patients, and ensure being part of TeamUHD is something we all feel and benefit from each day.

The three priorities work together to achieve these outcomes (TO BE REPLACED)



Our priorities set out at high level what we are trying to achieve. The following pages describe how we will achieve them.

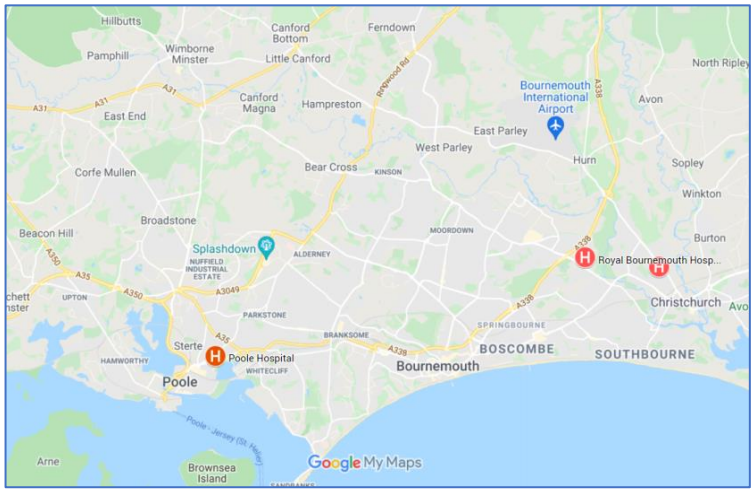
This is an approach that puts a safety and learning culture at the centre of how we deliver care and our major change programmes. This means being a well-led organisation, with leadership expected of all staff, with the empowerment and drive for continual improvement in every service. How we go about delivering the three priorities will be as important as selecting and delivering the priority itself. Only by doing the work in a well-led way, through high performing teams, can excellent care be sustainable.

It's important to be clear that delivering the following annual operational objectives underpins our ability to deliver on our priorities, and conversely, focusing on the three priorities outlined earlier will directly support the dlivery of these annual objectives.

1.1 Overview of the Trust

University Hospitals Dorset NHS Foundation Trust (UHD) was formed in October 2020 with the merger of Poole Hospital NHS FT and Royal Bournemouth and Christchurch Hospitals NHS FT bringing together teams to service Dorset and beyond.

The Trust spends approximately c£680m and employs c 10000 staff across 3 hospitals – Poole Hospital (PH), Royal Bournemouth Hospital (RBH) and Christchurch Hospital (XCH).



The Trust's services include the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services, delivering the following annual activity:

- 153,000 Type 1 ED attendances
  (Type 3 are transferring to DHUFT on 1st April 2022)
- 73,000 Non-elective admissions
- 73,000 Day case treatment
- 536,000 Outpatient attendances

- 36,000 Planned admissions
- Over 4000 births

These services are provided primarily to a catchment population of approximately 600,000 in the Bournemouth, Poole, Christchurch and east Dorset and New Forest areas.

Specialist services such as vascular, oncology, neurology, cardiology are provided for a wider population of 1 million and most of our services are delivered with our partners including GP’s, social care, ambulance and other NHS services and many others.

UHD is undergoing a major building programme in preparation for service reconfiguration. This will create a planned hospital and an emergency hospital from 2026. During 2022/23 we will see the continuation of significant building works and more importantly the integration and development of teams that are ready for the planned service changes. These changes will deliver significantly better, safer and more sustainable care for the population.

1.2 Trust Vision, Mission and Values

Underpinning the Mission and Vision are ***our UHD values*** ***(***https://www.youtube.com/watch?v=g18KK8e-x_U&t=6s***)*** . These underpin everything the Trust does and defines how patients and visitors are treated, and also how staff treat each other. The values are embedded into every part of UHD, such as recruitment, appraisal and development.

The Values were drawn up by our staff, facilitated by our Change Champion volunteers, following widespread listening and testing.

UHD has a set ***five strategic objectives*** which are progressed over multiple years. These are:

1. Continually improve quality of patient care
2. Be a great place to work
3. Use our resources well
4. Be well-led and an effective partner
5. Transform our services to better serve patients

Our strategic objectives are revised each year and specific actions set for the year ahead. For 2022/23 there are 15 specific actions as noted overleaf.

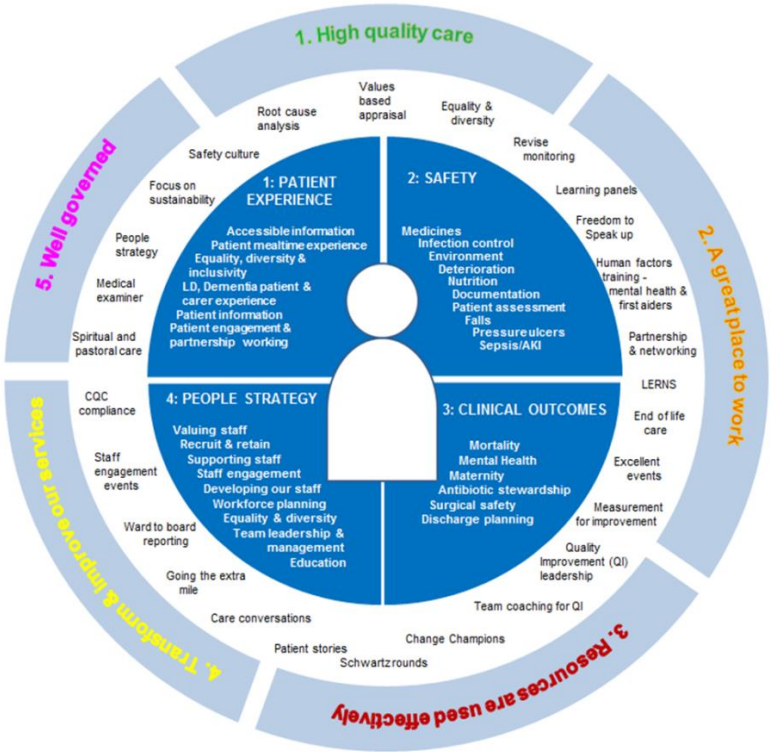
Strategic Objective 1: To enhance emergency care and hospital flow, and continually improve the quality so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience		**Exec Lead**
1.1	Improve the safety and experience of emergency patients and their flow, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partners and improving our own processes to support safe and timely discharge from hospital. To also improve the responsiveness and quality of Urgent and Emergency Care (UEC) as measured by a reduction in 12 hour waits in ED towards zero, minimisation of ambulance handover delays and same day emergency care outcomes supported by implementation of the UEC 10 Point Action Plan.	CMO/ CNO
1.2	To redesign and transform **outpatient services** with a 'digital first' offer, improving access to care, diagnostics strategy delivery, reducing travel times, and through effective completion of care pathways.	COO
1.3	To deliver wide range of **patient safety quality priorities,** using a quality improvement (QI) approach, across the Trust including: • Quality account priorities including Deteriorating Patient and Safety Checklists. • Priorities for 2022/23 including Acute Kidney Injury/Dialysis Management, Blood glucose management, the deteriorating patient in ED and medical/pharmacy communication. Improving against Stroke and Trauma pathway quality standards	COO
Strategic Objective 2: To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.		**Exec Lead**
2.1	To continue to engage with staff at all levels to ensure we maintain focus and realise the **health, wellbeing and Covid-19 recovery** needs and priorities of all our people, investing in appropriate provision of holistic interventions and resources. To engage with staff so that they feel valued and listened to and to strengthen our compassionate and inclusive culture, acting on staff culture champions recommendations and demonstrating success through the national staff survey.	CPO
2.2	To support teams in coming together to operate as a **single team** across UHD sites, embedding our values and behaviours, policies and processes and to identify talent and raise performance and staff engagement across the Trust as measured by an improvement the staff Integration Survey	CPO
2.3	To deliver the Trust's **people strategy** by developing effective and responsive People services, policies and practices for each stage of the employee cycle.	CPO
	This will include workforce planning, recruitment and retention, training and education, employee relations, temporary workforce and workforce systems.	
2.4	To champion **equality, diversity and inclusion** across UHD through positive action and promote initiatives which continue to improve results against workforce equality standards (e.g. WRES and WDES). Implement the National Patient Strategy requirement to develop a just culture across UHD as part of a ICS workforce plan. Define and agree measures to monitor implementation of inclusive leadership, equal opportunities in career development and endorsement of staff networks.	CPO
Strategic Objective 3: To arrange our people and services to best address the planned care backlog, ensuring that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets.		**Exec Lead**
3.1	To deliver a Covid restoration programme that reduces the **elective backlog,** increases activity to pre-pandemic levels and returns waiting times and waiting patient numbers towards the national standards for elective, cancer, diagnostics and emergency care.	CFO
3.2	Agree and deliver a **sustainable budget,** including delivery of the Trust Cost Improvement Programme. This includes realising the opportunities identified in the Getting it Right First Time (GIRFT) and Model Hospital benchmarking data.	COO
3.3	To update and deliver our **green UHD Strategy** and Plan – including reducing our carbon footprint, improving air quality and make more sustainable use of resources.	CSTO
Strategic Objective 4: To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.		**Exec Lead**
4.1	To improve **partnerships and engagement** with staff, governors, patients, local people and key stakeholders through: • a communication and engagement plan, delivered over the year. • Further develop our BU partnership and tangible benefits • Host the Dorset Innovation Hub on behalf of Dorset partner supporting spread of proven innovations	CEO/ CSTO
4.2	Work with partners to address **health inequalities** and improve population health management, preventing ill health and promoting healthy lifestyles.	CFO

Strategic Objective 5: To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our		**Exec Lead**
5.1	Develop the **reconfiguration plan** to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for new estate and new models of care. To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/3	CSTO
5.2	Work with system partners in establishing the **Dorset ICS** and within that develop the Dorset provider collaborative.	CEO
5.3	Implement the UHD **digital transformation strategy**: • Progress digital transformation and play an active part in the key Dorset transformation plans programmes • Progress a Digital Dorset Shared Service • Procure and implement the Strategic Integrated Imaging Service: a digital diagnostics image sharing platform for Dorset. • Create the Strategic Outline Case and Outline Business Case for the Dorset Electronic Patient Record system • Ensure that the IT infrastructure and BAU support services are fit for purpose with minimal down-time and the technical layers are subject to a rolling stock replacement programme. • Achieve a compliant Data Protection and Security Toolkit submission.	CIO

2. Quality of Care and Safety

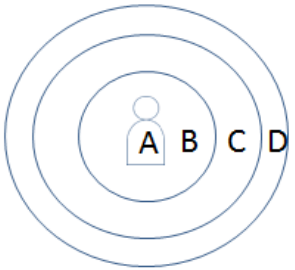
2.1 Quality and Safety

The trust's quality priorities are arranged within the domains of quality; safety, patient experience and clinical effectiveness (clinical outcomes). High quality care can only be achieved when all three of these domains are present equally and simultaneously.



We recognise the fundamental role that our staff play in delivering high quality care and our people strategy therefore forms the fourth domain of our quality strategy. Individual priorities within each domain are derived from the national guidance and triangulation of internal data from a variety of sources including patient feedback, external stakeholders, regulators, governors and incident reports.

Each of the three pillars of quality; Patient Safety, Patient Experience, Clinical Outcomes/Clinical Effectiveness are monitored through the respective reporting groups in the trust governance framework (see below).



A. Approach philosophy
B. Pillars of Quality – focus of priorities
C. Work streams and processes
D. Strategic goals

Quality reporting through these structures supports to review, analysis and delivery of key metrics related to patient experience, safety and effectiveness of services up to the board of directors.

Quality reporting is based on the Care Quality Commission (CQC) key lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led). Board and Board subcommittee reporting support wider quality assurance processes such as peer review, clinical audit, and internal and external audit. Information in the Board and Quality Committee reports routinely includes progress on quality, patient safety and patient experience metrics including:

- Risk register additions, updates, controls, action plans and assurances
- Serious incidents, incident reports, near misses and learning outcomes from investigations and reviews Trends – current and future risk, assurance and quality issues
- Internal comparisons and external benchmarks
- Directorate, specialty, ward and consultant level data where appropriate
- Quantitative and qualitative data
- Patient stories and patient feedback
- Statistical interpretation and analysis

Specific objectives for 2022/23:

The Quality priorities for 2022/23 have been derived from shared learning from patient and staff safety incidents, clinical audits, claims and inquests, Medical examiner reviews, peer reviews and Mortality reviews during 2021/22.

The main patient safety quality priorities for 2022/23 are as follows:

- Fluid Management
- Difficult IV Access (DIVA)
- Deteriorating Patient
- Safety Checklists
- Consent
- VTE risk assessment and prophylaxis
- Acute Kidney Injury pathways and management
- Blood glucose management
- Medical and Pharmacy communication processes

2.2 Care Quality Commission (CQC)

RBCH and PHT were inspected separately in 2018 and 2020 respectively. UHD remains unrated against all core services.

Location level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Overall	NA	NA	NA	NA	NA	NA
Christchurch Hospital	NA	NA	NA	NA	NA	G 25/2/2016
Poole Hospital	RI 31/1/2020	G 31/1/2020	O 31/1/2020	G 31/1/2020	G 31/1/2020	G 31/1/2020
The Royal Bournemouth Hospital	G 18/6/2018	G 18/6/2018	G 18/6/2018	G 18/6/2018	O 18/6/2018	G 18/6/2018

The Care Quality Commission (CQC) undertook an announced focused inspection of University Hospitals Dorset NHS Foundation Trust in April 2021. The inspection looked at leadership, culture, governance, information management and learning at the trust following concerns about the safety and quality of some areas.

The inspection focused on individual elements of the CQC well-led key lines of enquiry. The CQC did not rate the trust at that time.

During the inspection, the CQC found leaders had the skills and abilities to run the service. Managers understood and managed the priorities and issues the service faced and were visible and approachable in the service for their staff. The CQC noted that the culture was open, and staff could discuss errors without fear of reprisal. There were effective processes focused on learning from mistakes and continuously improving practices.

However, the CQC found that governance systems were not always effective in determining patients' pathways of care and treatment. In a small number of cases the systems used did not prevent cancer treatments from being missed, delayed or terminated in error. The CQC recognised that the trust had taken steps to address these gaps and noted further actions were in place to mitigate risk. It was recognised this was a new organisation and the trust leadership knew there were gaps that needed addressing in some areas, and processes that needed to be improved.

CQC reviews will remain an important part of the quality approach at UHD and we will continue to use these to understand where further improvements to our services can be made.

2.3 Maternity Services

The planning guidance sets out the requirement to support the Immediate and Essential Actions arising from the Ockenden Report. This will include a calculation of the Birth Rate Plus metric for UHD and we anticipate that these will lead to a requirement for around a further 20 midwifes.

Ockenden Report - Immediate and Essential Actions

- Additional midwifery workforce
- Enhanced obstetrician availability
- Introduction/development of maternity MDT

The second of these actions requires the further provision of consultant obstetrician time to support the provision of twice daily ward rounds; consultant leadership for foetal heart monitoring; and the introduction of Maternity MDTs.

The Trust will be bidding against these national monies early in 21/22 and continues to work in partnership with the Local Maternity Services to oversee the provision of maternity care for the local population.

2.4 Quality Improvement and Innovation

The Quality Improvement (QI) strategy and Innovation strategy were approved by the UHD Trust Board in early 2021, have been implemented throughout 2021/22 and will continue to be delivered through 2022/23.

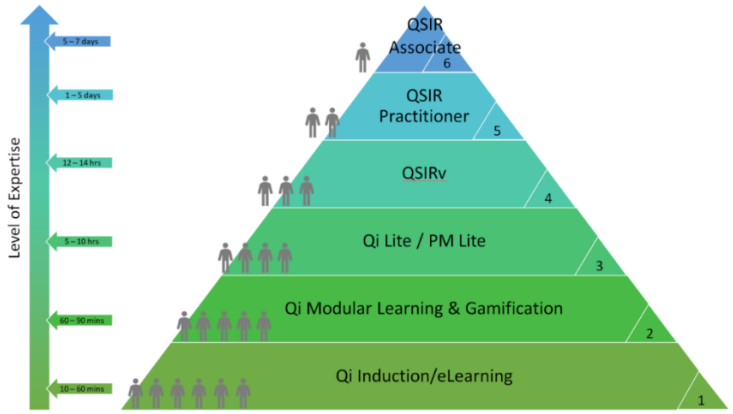
The strategies underpin the Trust value of ‘always improving’ and seeks to develop a culture of continuous improvement and learning across the organisation in which everyone is empowered to make changes to improve the quality of clinical and non-clinical services to improve patient care.

UHD has been selected as one of four Trusts in the country to host a Health Foundation funded innovation hub on behalf of the Dorset system in order that spread and adoption of innovation can be accelerated.

During 2021/22, implementing the QI strategy delivered:

- ICS-wide QI lite training course led by UHD, rolled out in <6 months
- A successful QI celebration day, with hundreds of web page views and thousands of social media views
- QI Training (using national QSIR model), QI project registration and QI website all developed
- Over 150 QI projects registered and supported
- Strategy and Culture of improvement work underway to support ‘always improving’
- UHD QI priorities supported - improved processes rolled out with over 14 large projects supported

For 2022/23 we aim to build on our foundation year and continue to develop our culture of improvement while building capacity and capability in QI and innovation methods though our multi-tiered training programme (QI example below).



Our plans to develop a culture of continuous improvement include:

- Develop a continually improving UHD via implementing QI Strategy and innovation strategy
- Deliver QI and innovation events
- Deploy QI and innovation training in partnership with ICS, and within UHD.
- Develop community of improvers and innovators in each care group/directorate
- Demonstrate the benefits of improvement approaches to the UHD Trust Board and stakeholders

Our innovation programme includes:

- Delivery of Medtech mandate innovations across Dorset (4 delivered in 2021/22 and 7 in 2022/23)
- Delivery of 5 priority system innovation projects
- Development of spread and adoption communications
- Deployment of the training and development programme
- Showcase events and learning sessions for partners

The UHD QI main priorities for the year include completion of the 2021/22 priorities and supporting the patient safety quality priorities as outlined in the Quality chapter above.

3. Organisational Development and Workforce

3.1 People Strategy

Our People Strategy which launched in 2021 sets out how we will unite our workforce behind our vision and make our new trust a great place to work. Our people have remained under increasing pressure since the response to Covid-19 began which is why it remains critical that we look after our people. Our People Strategy continues to drive the actions needed to keep our people safe, healthy and well, both physically and psychologically, and provide the necessary support and development needed to continue to deliver the highest possible standards of care in an environment of high demand, and at a time of significant change in the way patient services are organised and delivered across Dorset.

Successful delivery of our strategy will support us to improve our people's experience and ensure the trust is a great place to work. We recognise the importance of engaging and involving our people, and despite the challenging time ahead for us and for the wider NHS, it is essential that we hold this at the heart of what we do.

We know there is a shortfall of trained people to meet the rising demands for healthcare and that we will need to be more flexible, creative and innovative in how we attract, retain and develop our people, to enable us to fulfil our core purpose and achieve our vision with a key focus on workforce planning. Our People Strategy has five key action themes, which, through service integration, will enable appropriate support and care for our people while strengthening our organisational capabilities. Our work continues to be underpinned by the principles of the NHS Long Term Plan, the CQC Well Led domain and the NHS People Plan.

We recognise that there is a lot to do, and that we have some real strengths to build on, specifically the extraordinary commitment of our people to deliver excellent patient care.

Key Actions for 2022/23:

Supporting the Health and Wellbeing of Staff and taking action on recruitment and retention

Our focus continues to be on how we enable staff to be healthy in 'body and mind', to help them recover effectively and face the challenges of a post pandemic world.

We recognise that recovery will be different for everyone and there is no one-size fits all. This highly personalised experience will include the need to support rest and recuperation, mental, emotional, physical and financial wellbeing as well as changes to work / life practice, family / social life and loss and bereavement. As we move into stage

two of our second-year plan for staff recovery, our focus continues in the following areas:

Compassionate and Inclusive Leadership

Our expressions of gratitude to staff, in recognition and acknowledgement of what we have been through, will be universal with no differentiation. We will continue to place health and wellbeing at the heart of our line manager conversations and communicate clearly and consistently. Ensuring the strong voice of staff is essential to ensure their involvement and innovation. We recognise colleagues that most need help are the most unlikely to speak up. We will also continue to face the inequalities agenda head-on.

Key actions:

- continue focussed work on the Trust's cultural development programme to embed organisational values and ensure the voice of our staff continues to be heard. We will focus on: a) our *'You Matter'* campaign for staff reward and recognition b) getting 'back to basics' and improving staff experience c) implementation of a trust wide *Thank You* system c) strengthening implementation of values-based appraisal

- further develop our leadership and lifelong learning offers for staff including a) Level 7 Leadership Apprenticeship in partnership with Bournemouth University and b) introduction of a modular programme to support basic people management skills and competencies
- introduce a talent management framework in line with the national *Scope for Growth* initiative and participate in a national pilot study aligned to our matron development programme
- review the 2021 staff survey results at care group / departmental level and design improvement interventions, including:
    - increase in % BAME composition target to improve leadership diversity by 2025
    - improvements in our Black, Asian and minority ethnic disparity ratio
    - continue to implement priorities within our *Leading for Equality, Diversity and Inclusion* plan and health inequalities within our staff groups
- continue to enhance staff network engagement and intersectionality to strengthen contribution to organisational decision-making process

Systemic Wellbeing Offer

Our enhanced wellbeing service will continue to meet the need for staff access to immediate, acute psychology support. It will be integrated and coordinated for sustainability with a focus on prevention and organisational resilience. We will also focus on local interventions, supporting line managers to have 'psych savvy' conversations with staff.

The Trust has launched a new Managing Attendance Policy which recognises the need for staff to recover after periods of ill health by offering an extended phased return programme.

Key actions:

- further develop our Mental Health First Aid (MHFA) and Wellbeing Ambassador programmes
- embed a range of targeted education and support sessions for line-managers
- continue to support the work of our Freedom to Speak Up Guardian and ambassadors to identify staff areas of concern and help remove any barriers staff may face in speaking up
- increase proactive health and wellbeing initiatives enabling staff to remain well at work
- review "hotspots" of MSK injury-reviewing processes and working patterns and continue to work closely with the ICS MSK team
- Continue work with the respiratory Physiotherapy team in running the long covid rehabilitation programme for UHD staff
- Further develop the trauma pathway to include running a regular "stabilisation group" in collaboration with the ICS and Steps2Wellbeing along with refining referral pathways and co-developing support options for UHD staff

3.2 Organisational Development & Integration of Teams

Since the merger in October 2020 much progress has been made in teams coming together to improve services for the benefit of patients. Single leadership teams are in place across the Trust in senior clinical and managerial positions and early patient benefits are being delivered in clinical services such as stroke, cardiology and older peoples services.

The Trust cultural champions have completed work on how staff would like to be valued and recognised with a series of recommendations that are being taken forward within the Trust. Work on embedding the Trusts Mission, Vision and Values has continued with events and work programmes throughout the year.

In the past year there have been many successes – there were changes made to the national merger guidance that reflected UHD input and will hopefully make the merger process more grounded and easier to navigate for others, completion of post-merger actions has continued (with over 50% of post-day 1 actions complete), a care group integration assessment has been undertaken that has highlighted areas on which to focus and is supported by an action plan based on staff feedback that is in place to get the basics right.

There is however much still to do. The pandemic has bought about delays in the bringing together of teams in some services at Tiers 4 and below and planned cultural changes are still very much underway. Support for leadership development and team integration is in place with teams developing their own plans for coming together to be 'match fit' for the reconfiguration in 2024-2026.

Teams are Everything

Post pandemic, staff will continue to need supportive relationships with those they work closest to and we will prioritise support to encourage strong social bonds within our home teams.

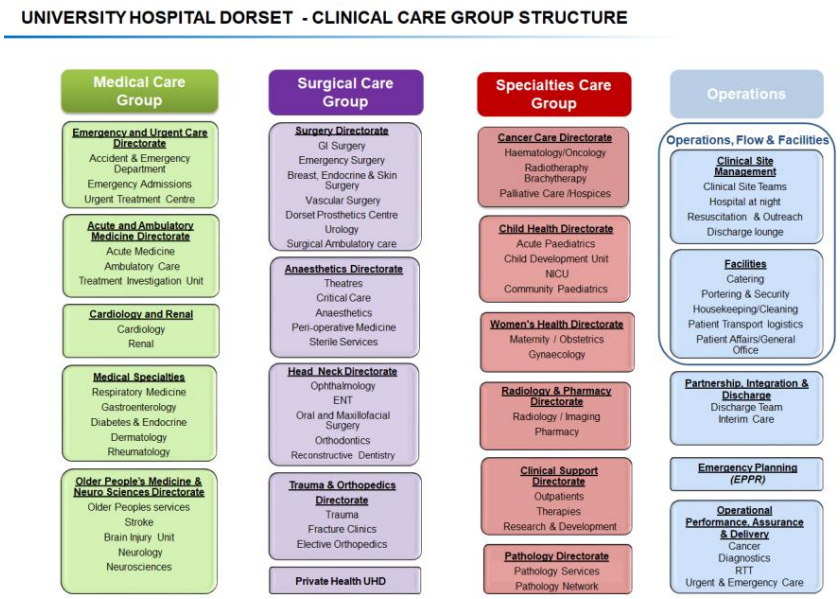
Key actions:

- embed effective team development e.g. Affina Team Journey at directorate and specialty level as part of COVID-19 recovery, service transformation and our organisational change programme

- continue to provide team interventions e.g. action learning sets, coaching, debriefing sessions and peer review facilitation to support resilience and reflective practice

Refreshed plans have been adapted to build on the lessons learned through the pandemic and the opportunity of bringing teams together to improve services can now be more fully taken forward.

The clinical structure implemented on the first day of merger has remained largely in place with some minor evolution as expected. The care group structure is outlined below.



3.3 Workforce Challenges

Workforce Planning, recruitment and retention

During 2022/23 we will focus on Workforce Planning by generating information, analysing it to inform future requirements of staff and skills and translating that into a set of actions that will develop and build on the existing workforce to meet UHD's future resource requirements.

Workforce plans are iterative and do change throughout the year in response to initiatives that may not have been known at the time of business planning, for instance additional money being made available for new initiatives; new commercial venture opportunities; or services currently provided by the Trust being put out to competitive procurement, with the potential for this to result in a TUPE transfer of staff to a new organisation.

Looking forward, the effectiveness of the workforce plan will be reviewed monthly by the HR Team in conjunction with the Operational Leadership Group, and a quarterly report will be presented to the Workforce Strategy Committee and the Executive Management Committee. Trust Board will be assured of progress via the Workforce Strategy Committee which is chaired by a Non-Executive Director.

Recruitment

Current market forces mean significant challenges in sourcing candidates for an increasing number of hard to fill roles, so improving our reach and attraction of candidates via an increased use of social media and focused marketing is important to us.

Key actions:

- consolidate workforce planning activity across UHD and the wider system and communicate the core requirements of the individual stakeholder in the overall short, medium- and long-term Workforce Plan.
- engage in national and regional recruitment programmes and initiatives for key roles, including international nursing and health care support workers [HCSWs]
- work alongside the ICS to further develop the HCSW vocational scholarship
- increase our uptake on the UHD preceptorship programme and apprenticeship scheme for both clinical and non-clinical roles
- full implementation of refreshed ESR Exit module and BI analytics to develop an evidence-based attraction and retention strategy that supports both local and system wide staffing gaps
- reduction in agency spend and off framework agency usage
- expansion of the international nurse offer to define the pathway of development for newly appointed international nurses towards their first band 6 role
- implement the UHD Temporary Staffing model with resources focused on the attraction and retention of a flexible temporary workforce as a priority.

Retention

Retaining our current workforce remains a priority for us and we will endeavour to offer more flexible, varied roles.

We recognise that flexible working is about more than just retention. It can unlock new opportunities and contribute to people's mental health, wellbeing and engagement with their role, and we know that in the NHS more engaged staff leads to better patient care. We have worked in partnership with staff side colleagues to develop and agree UHD's new Flexible Working and Agile Working Policies, in line with the NHS People Plan principles.

We also recognise that the fair treatment of staff supports a culture of compassion, fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.

Key actions:

- embed Just and Learning principles into our core people management training
- continue to develop and support the offering of flexible working practices.
- develop attraction and retention incentives at local and system wide level
- Continue to develop and embed the UHD employee value proposition to support reputation as a 'good place to work'

- ensure elective care pathway restoration includes a) talent management and succession planning and b) bespoke health and wellbeing offer for staff and patients

4. Operational Performance and Recovery

4.1 Introduction

In our second year of operating services alongside the ongoing level of healthcare demand from COVID-19, teams have continued to rise to the challenge of restoring services, reducing the backlog of care that is a direct consequence of the pandemic, whilst also meeting the demands for transforming the way we deliver safe, high quality services for our community. In 2022/23, its crucial that we continue our resolve to ensure the highest clinical priority patients are prioritised, we complete any outstanding work for cancer recovery against our ambitions and we continue reforms to urgent and emergency care.

4.2 Organisational Performance and Challenges

In 2021/22 the Trust continued to focus on the planned response to the COVID-19 pandemic and the elective recovery programme.

The response to the COVID-19 pandemic included compliance with national infection control guidance and social distancing. This resulted in a reduction in elective and non-elective capacity and increased waits and numbers waiting for routine planned work.

A focus on re-establishing all cancer and urgent activity during the recovery periods (between peaks in Covid-19 positive activity) has also resulted in the Trust undertaking less activity in the re-established outpatient, procedure and theatre sessions for some specialities.

Consequently, the Trust's position against national standards was mixed in 2021/22 with good performance against diagnostics (DM01) for the first 8 months of the year but continued challenges against constitutional standards such as Referral to Treatment (RTT) and cancer waiting times, meantime in ED and ambulance handovers. There have been further improvements against a number of urgent care indicators such as arrival time in the Emergency Department (ED) to initial assessment and arrival time in ED to treatment.

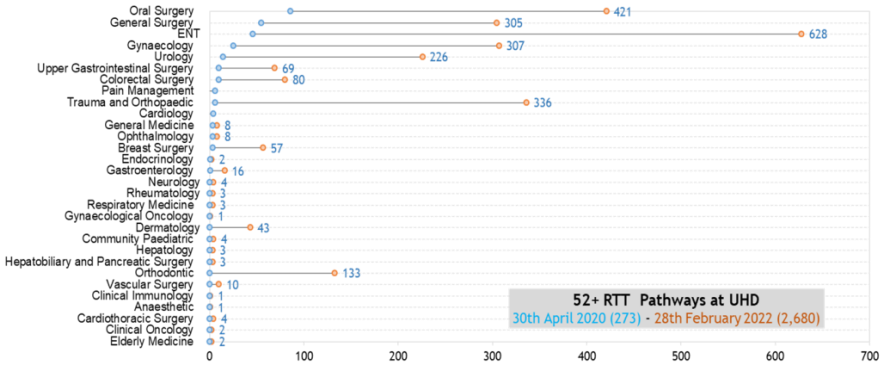
These challenges are multi-factorial but include increases in demand for cancer referrals, workforce capacity gaps, flow and inpatient capacity impacted by Covid and Infection Prevention and Control (IPC) measures, as well as patient's choosing to delay treatment due to the concerns related to Covid-19.

Referral to Treatment

In 2021/22, the RTT waiting list size has increased to over 54,000 and the RTT performance increased to be consistently above 60% since May 2021 against a target of 85%.

The chart below highlights the growth in over 52 week waits with Oral Surgery, Ear Nose and Throat (ENT), General surgery, Gynaecology and Orthopaedics standing out.

There have been overall improvements in the number of patients waiting for extended periods of time for treatment with the number waiting over 52 weeks reducing to 2,680 in February 2022. The proportion of patients waiting over 78 weeks has also decreased with plans to reduce the number of patients waiting over 104 weeks by March 2022.



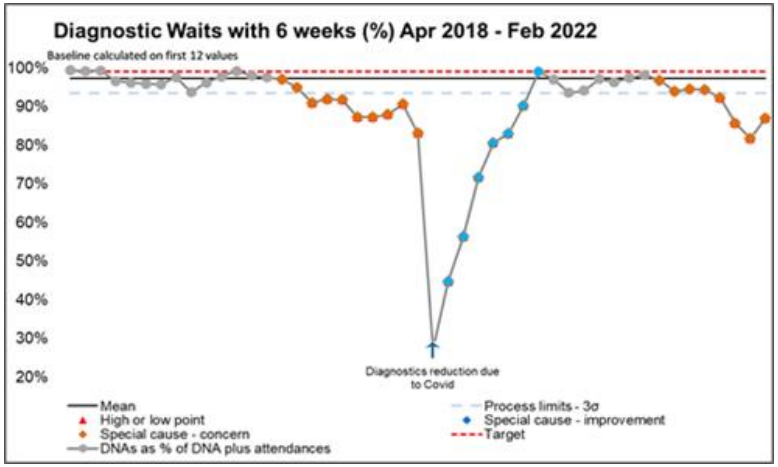
Cancer

Cancer referral numbers continue to exceed previous years putting additional pressure of several services at all stages of the pathway. Despite these pressures the Trust achieved the 31 day Cancer standards. The 62-day standard was not met in 2021/22 and 28 day Faster Diagnosis standard not achieved in Qtr 3. Diagnostic waits and late referrals have been contributing factors alongside surgical capacity.

	Measure	Target	Q3 20/21 - FINAL	Q4 20/21 - FINAL	Q1 21/22 - FINAL	Q2 21/22 - FINAL	Q3 21/22 - FINAL
UHD	Cancer Two Week Wait	93%	N/A	N/A	N/A	N/A	N/A
	Cancer Plan 62 Day Standard (Tumour)	85%	78.6%	77.8%	79.1%	76.9%	70.9%
	62 Day Screening Standard (Tumour)	90%	94.1%	88.1%	88.1%	81.0%	87.0%
	31 Day First Treatment (Tumour)	96%	97.0%	96.7%	97.1%	97.4%	96.8%
	Subsequent Treatment - Surgery	94%	95.4%	90.5%	91.2%	92.2%	93.9%
	Subsequent Treatment - Radiotherapy	94%	98.7%	99.0%	99.0%	97.8%	100.0%
	Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	99.7%	98.8%	98.1%	100.0%
	Faster Diagnosis	75%	80.7%	79.1%	76.5%	75.4%	66.6%
	Over 104 days (treated in month)	N/A	26	16.5	30	28	36

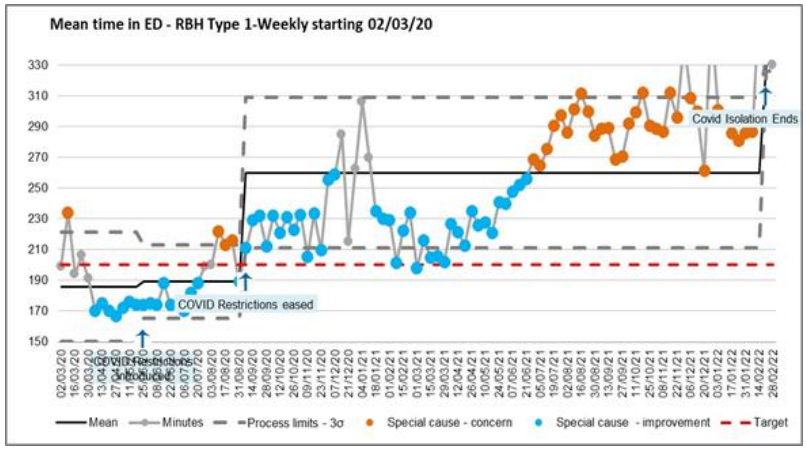
Diagnostics

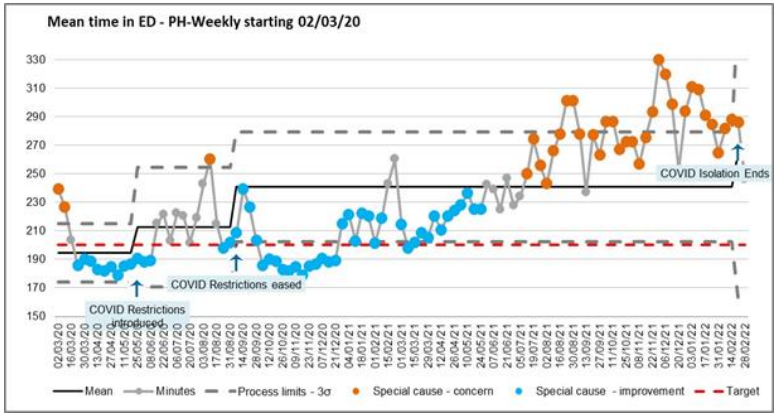
The graph below shows the strong recovery of the 6 week diagnostic standard during the latter half of 2020/21 and the first half of 2021/22. Performance has shown improvement in February following some deterioration over the last few months. Increased demand for diagnostics has been experienced as the Trust increases elective activity to support recovery and due to rising urgent referrals. The most challenged speciality continues to be endoscopy.



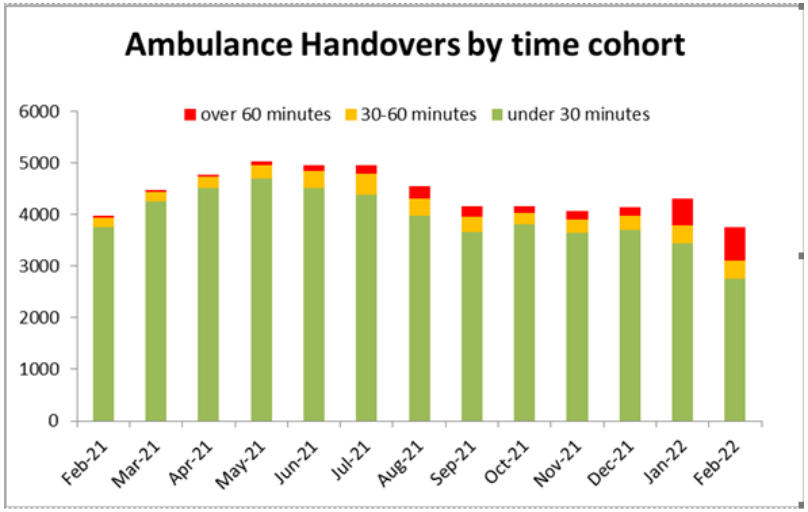
Urgent and Emergency Care

Both emergency departments made improvements in overall mean time during 2021/22 despite increased demand and delays in discharging patients medically ready for discharge.





The overall increased stay for patients remains above the standard and has had a detrimental impact on the national Urgent and Emergency Care (UEC) metrics, particularly 12hr Decision To Admit and ambulance handovers in recent months.



4.3 Urgent and Emergency Care

Key Challenges

Covid has meant the sustained implementation of several IPC related pathways and processes which have adversely impacted patient flow, operational capacity and timely discharges.

This continues to include reduced bed capacity to facilitate compliance with patient distancing, coupled with ongoing lost capacity due to both outbreaks and a requirement to maintain a COVID bed base on both inpatient UHD sites. Bed modelling across UHD had previously demonstrated a gap in bed capacity which required mitigation. Furthermore, the impact of Covid on urgent and emergency patients demonstrates an increase in higher acuity presentations and a sustained backlog of patients who have avoided services now attending hospital later in their disease pathways.

Achieving the new national Urgent & Emergency Care standards is a challenge but as existing pilot sites, we strive to continue to provide safe care and good clinical outcomes for our patients.

Actions

To oversee and deliver the 2022/23 priorities and operational planning guidance and the National UEC 10 Point Action Recovery Plan, UHD has launched an Improving Hospital Flow Programme reporting to the Trust Management Group.

There are 4 key workstreams – ED, SDEC, Operational Flow and Discharge that report to a single steering group. Each workstream is led by a senior team with dedicated programme support and are accountable for delivering transformational change required to deliver the 2022/23 Priorities. Additionally, UHD will continue to use ECIST to support its recovery programme.

Each workstream has detailed action plans and governance in place to ensure these are tracked and delivered. In terms of the 2022/23 Operational Guidance we will specifically deliver:

Reduce 12-hour waits in EDs towards zero and no more than 2%

UHD has a good record of both measuring and delivering waits of no more than 12 hours, however with increased crowding in the Emergency Department this has been a challenge. The Improving Hospital Flow Programme will oversee the recovery and transformation work streams that will contribute to the eradication of all waits longer than 12 hours that are not clinically justified.

We aim to Improve Ambulance Response Standards - minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes: - eliminating handover delays of over 60 minutes - ensuring 95% of handovers take place within 30 minutes - ensuring 65% of handovers take place within 15 minutes

Ambulance handover delays have become a challenge in UHD when the EDs become overcrowded. The Trust will continue to develop and refine both escalation triggers and responses both internally and externally to respond to the risk of Ambulance delays and make meaningful reduction in the numbers of Ambulances that are unable to hand over to the ED within 15 minutes.

Same day Emergency Care (SDEC) is available 7 days per week, 12 hours per day.

The second workstream of the Improving Hospital Flow Programme is specifically tasked with ensuring local SDEC provision meets national recommendations for accessibility both in terms of time, and breadth of pathways. UHD will challenge services to meet these requirements, and to develop strong cases to reprofile funding from beds to SDEC services.

Ensuring there is a full range of available options in the Directory of Services to meet local need

With partners UHD will continue to develop its Directory of Services accessible from primary care, paramedics and NHS111 to ensure patients can be seamlessly referred to the right service directly, without the need to attend the ED.

Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

With partners UHD will continue to develop the UTC provision on both acute sites and facilitate rapid streaming from the earliest decision maker in ED to the UTC environment or prevent attendance into ED entirely.

Risks and Issues

- Face to Face Access in Primary Care
- Workforce – wellbeing, sickness, vacancies, recruitment
- Capacity and technology to divert patients to Minor Injuries Units (MIUs)/Urgent Treatment Centres (UTC) or other appropriate services
- Timely availability of booked appointments
- Timeliness, effectiveness and continual nature of local public communication
- Increase in minors' attendances over the Summer
- Inappropriate referrals
- Complexity of referral/booking processes/symptoms
- Funding/ability to implement capacity mitigation schemes (e.g. SDEC)
- Ability of partners to respond to demand pressures and avoid additional impact on UHD
- Challenges in developing intelligent conveyancing as a means of balancing Ambulance demand and ED crowding
- Changing to funding of IAGPS potentially destabilising DIUCS provision and primary care access from UEC.
- Cultural shift from 'ED work' to 'system work' (internal and external to organisations)

Assumptions

- System plans are developed to deliver the community-based elements of the UEC 10-point plan
- DIUCS/UTC develops as an integrated element of the UEC offering in Dorset
- Transformation initiatives and funding support for schemes will facilitate deliverables, safe care and progress against key standards
- Key ambitions against indicated national UEC standards will be achieved if actions delivered and risks mitigated

4.4 Patient Flow & Bed Capacity

Underpinning the Trust's surge and capacity planning is our bed modelling. With the backdrop of lost bed utilisation due to IPC risk assessment as well as reconfiguration of areas to meet Covid demands (e.g. Blue ITU and cohorting of Covid patients across acute wards) the model demonstrates the need for 'escalation' beds, above core for initial months post winter pressures. A key assumption in our modelling, as well as out bed gap mitigation plans, is the role of the Home First and Hospital Discharge Programmes. There are two key

components of the drive to ensure that patients are not admitted unnecessarily and are discharged when they no longer require the hospitals' services. These are Home First and Community bed based services.

Home First

The following table shows some of the highlights of the Home First programme.

Pathway	Proportion of patients	Features / "What Does Good Look Like"
0 – Discharge Home	50%	Voluntary sector provision. Provides rapid short term 'settling in support' to facilitate timely discharge. Services act as a 'facilitator' to access other smaller place based voluntary/third sector services as required
1 – Discharge Home with Support	45%	Five Integrated cluster teams with responsibility for receiving referrals, determining pathway, allocating care, provide rehab / reablement, case management and assessment for ongoing need. Standardised processes across teams. Integrated/ single IT systems to support processes and data collection.
2 – Discharge to Interim Beds	4%	Range of commissioned beds to meet needs. Single bed management function (flow) and leadership. Step up for known patients or via Acute ambulatory services.
3 – Discharge – Complex and End of Life	1%	Robust hospital and centralised processes for case managing people out of hospital on P3 (and P1 complex and EOL). Timely discharge on P3 to patient's final destination. Timely assessment for ongoing funding. In reach Social Workers supporting ward based discharge planning decision with wider MDT.

Further improvements for the Home First Model and discharge offer during 22/23:

- To agree the ambition / trajectory for improvement e.g. 50% reduction in LLOS from March 2022 and maintained
- Baseline for "admissions not avoided" in ED and Assessment Units where community services have not been able to respond to avoid admission to an inpatient ward (Criteria to Admit enforced via clinical criteria)
- Design a Pathway 1 & 2 Community Service Offer to increase discharges via Home First & Decision to Admit

(D2A) from ED & Assessment Units across the acutes to avoid a long length of stay in hospital
- Commencement of weekly “complex / stranded patient meeting (14 & 21 day LOS)” with representation from Dorset ICS partners to expedite discharge arrangements for patients referred to community services via Home First / D2A.
- In reach hospital Social Workers to support complex discharge planning.
- Establish a Dorset ICS escalation process for patients who do not meet Criteria to Reside, where a community offer for discharge has not been established e.g. within 72 hours of receipt of referral within the SPA / Cluster Team.
- Continue to work with external strategic partner to support the Dorset system and draw on learning from elsewhere.

Hospital Discharge Programme including Criteria to Reside (C2R)

The new Discharge to Assess guidance was issued during the COVID-19 pandemic and the Dorset System is being supported by NHSEI to facilitate timely discharge underpinned by a “Home First” model of care. The ethos behind this guiding principle is that patients receive acute hospital care when needed, only for the period required; underpinning quality of care and patient outcomes.

This Discharge to Assess guidance includes Criteria to Reside (C2R), which aims to move assessment out of hospital and into people’s homes – patients only remain in hospital if they meet a defined set of “clinical criteria to reside”. It is designed to provide an evidence base for identifying the on-going care needs of patients during and beyond the acute phase of care.

Key Benefits
- It’s good for patients – helps to ensure right care, best place at the right time. Reduces the clinical risk of hospital acquired infection and deconditioning by ensuring an optimised length of stay, supporting best patient outcomes.
- It reduces pressure on staff, wards and the front door; allowing our sickest patients to be admitted more quickly.
- It will inform our partners when and how to help and support; enabling effective demand planning.
- The information and data will provide assurance to regulators.

Actions
- Internal clinical focus on P0 and P1 patients with no criteria to reside (using clinical criteria NEWS scores led by senior decision makers)
- Continuing implementation plan which considers all aspects of C2R including engagement and awareness (rolling programme)
- Hospital Discharge Workstream in place to support Trust’s assurance framework and work with senior nurse leads to

include within quality metrics as well as part of the Care Group's performance.

- Have in place an improvement trajectory that is able to demonstrate progress or highlight where further work is needed.
- Future focus on internal processes that delay discharge.

Risks and Issues

- Demand (non-elective and/or elective) exceeds bed modelling scenario assumptions
- 'Staycations' and visitors to Dorset result in surge demand at peak periods
- Increase in the number of patients ready to leave requiring step down to community services
- Home First and Discharge to Assess capacity and pathways are unable to deliver further reductions in Length of Stay to offset the acute bed capacity gap
- Ability and capacity to support engagement and delivery across all clinical and ward teams in the Criteria to Reside framework
- Further Covid waves, outstripping planning assumptions
- Workforce gaps impacting on service delivery

4.5 Elective Care

Elective care covers a broad range of non-urgent services, from diagnostic tests and scans, to outpatient care, surgery and cancer treatment. The COVID-19 pandemic has had a significant impact on the delivery of elective care, meaning that many patients are now waiting longer for treatment than they were before.

Progress made during 2021/22

Considerable strides forward have been made during 2021/22 in support of recovery of elective care. Some of the key achievements are as follows:

We have achieved:

- Mobilisation of the Outpatient Assessment Centre as part of the Dorset Health Village concept to support high flow outpatient procedures and diagnostics within the community. Pathways include cancer, ophthalmology, orthopaedics, cardiology and breast screening.
- The introduction of Patient Initiated Follow Up (PIFU) pathways for key specialities with enhanced decision making to reduce OP follow ups.
- Introduction of Advice & Guidance (A&G) in dermatology, to ensure that patients are seen in the right place, at the right time by the right person.
- A targeted health inequalities approach to enhance the use of waiting list data to identify disparities in relation to waits for elective care using population health

management (PHM) and identification of key measures to support patients to ‘wait well’.

Key challenges

There are several key challenges impacting the recovery of elective care going into 2022/23. Some of these include:

- The impact of COVID-19 and urgency and emergency care, including trauma on elective activity has been significant, in reducing the availability of resource (i.e. staff and beds) and, in particular, exacerbating waiting lists for complex patients.
- Linked to the above, whilst mitigations have been applied throughout 2021/22 there remain patients on our waiting list that have waited over a year for treatment. With key challenges in Trauma and Orthopaedics, ENT, Oral Surgery, General Surgery and Gynaecology. Concurrently our plans must tackle capacity and transformation to address long waiting lists.
- The elective workforce is stretched and has been operating at pace for a considerable period of time thus impacting resilience and wellbeing. Workforce shortages relating to clinical and clinical support staff within key areas are negating elective delivery, and ongoing operational pressures inhibit the ability of our clinical and operational leadership to fully engage within service improvement at times.
- Theatre capacity is in high demand, whilst theatre efficiency and utilisation has not been able to be optimised due to workforce capacity gaps and an increasing reliance on the independent sector to provide additional activity, which brings an additional pull on the finite resources within our booking and admissions teams.
- The pandemic has both slowed and accelerated different pre-pandemic aspirations for the transformation of outpatient services to give patients greater control and convenience regarding their clinic appointments – by offering telephone or video consultations, empowering people to book their own follow-up care, and working with GPs to avoid the need for an onward referral where possible. As the Dorset system prepares for digital and pathway transformation of its outpatient services there is a need to lay the foundations of operational excellence within outpatients through a ‘getting the basics right’ programme.

In 2022/23 it’s clear that recovery of pre-pandemic and pandemic related performance will not be delivered without transforming the design and delivery of services across UHD. To realise the quadruple aims of transformation, to:

- Reduce unwarranted variation in access and outcomes
- Redesign clinical pathways to increase productivity
- Increase involvement of patients in decision making; and
- Accelerate progress on digitally enabled care

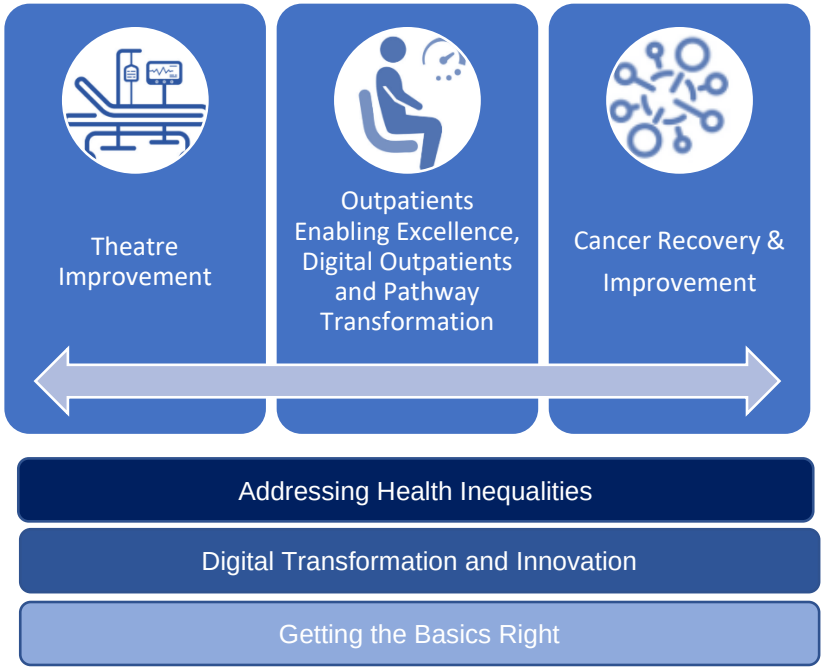
Our plan for elective care in 2022/23

The plan is centred around four areas of delivery:

- Increasing health service capacity
- Prioritising diagnosis and treatment
- Transforming the way we provide elective care
- Providing better information and support to patients

And three transformation programme areas:

- Theatre improvement programme
- Outpatients Enabling Excellence, Digital Outpatients and Pathway Transformation Programmes
- Cancer recovery and improvement programme (see section 4.3)



Each programme is underpinned by the three cross cutting themes of addressing health inequalities, digital transformation and innovation and getting the basics right.

Theatre Improvement Programme

- Theatre transformation is critical to supporting elective recovery. Building on work commenced in 2021/22 to optimise theatre efficiency and utilisation and improve staff and patient experience of theatres, through our theatre improvement programme, we will:
- Engage in a Regional Theatre Improvement Programme, working with Four Eyes Insight to maximise theatre capacity based on ongoing theatre optimisation analysis focusing on trauma and orthopaedics, urology and oral surgery.
- Review GIRFT and Model Health System opportunities and support clinicians to reduce variation.
- Introduce the Smart Theatre Scheduling Tool to enable a single approach to scheduling of patients for theatres.
- Implement a virtual pre-op assessment platform to enable virtual pre-op assessment and remote delivery of pre and post-operative education.
- Standardise operational procedures across sites, including re-energising 6-4-2 meetings and maximising operating capacity.
- Develop a workforce strategy, which addresses recruitment and retention, promotes staff wellbeing and a positive culture in the workplace.

- Identify further opportunities to better utilise community capacity and ensure that secondary care capacity is utilised appropriately.
- Establish perioperative care co-ordination team by April 2023

Outpatient Transformation (Enabling Excellence, Digital Outpatients and Pathway Transformation programmes)

In 2022/23 we will:

- Roll out the plan to maximise use of high flow outpatient assessment clinics at Beales as part of the Dorset Health Village concept. Key steps will focus on developing diagnostic pathways for additional specialities.
- Deliver a back to basics enabling excellence programme for Outpatient Services focused on achieving immediate and sustainable efficiency improvements to optimise the productivity of the service and improve staff wellbeing. Deliverables include:
- Standardisation of appointment guidelines, follow up booking processes and room booking processes.
- Optimisation of an Outpatient dashboard and its operational application.
- Creation and roll out of a speciality capacity model tool and approach.
- A single operating model and recruitment and retention strategy.
- Expand the activation of PIFU pathways in all Care Groups, moving or discharging a minimum of 5% of all outpatients to PIFU by March 23.
- Identify opportunities for referral optimisation and implement specialist advice services across the next priority tranche of specialities to deliver a minimum of 16 specialist advice requests per 100 outpatient first attendance by March 23.
- Optimise the use of virtual consultations to a minimum of 25% of all Outpatient attendances supported by communications and training in conducting virtual consultations to improve usage.
- Deliver Digital Outpatient transformation to improve the patient experience for people on the elective pathway by combining a range of digital technologies into a comprehensive service.
    - Establishing a patient 2-way booking portal to give patients and their carers the ability to proactively manage their appointment requirements, access information related to their care needs and improve clinic utilisation.
    - Use of robotic process automation to enable last minute slots to be more filled more effectively.
    - Deployment of digital dictation and speech recognition technologies to capture clinical notes directly into the patient administration system to reduce handoffs, improve quality of notes and reduce administration.

- Deployment of room booking software giving better control over room bookings, reduce administration and enable better utilisation of spaces.
- Standardisation of self check-in services (software & check-in kiosks) across UHD sites.

In 2022/23 we will also:

Increase health service capacity by:

- Work in partnership with high quality independent sector providers as part of our core offer to patients to secure the best outcomes in areas of high demand and reduce waiting times.
- Re-establish bed capacity consistent with UKHSA IPC guidance.
- Creating a better understanding of demand and capacity by rolling out demand and capacity tools across all specialties.
- Use data intelligently to develop insights on activity and performance which inform our understanding of the opportunity to deploy capacity for elective recovery, including addressing data quality issues.
- Delivering against the Derwent 3rd theatre project in Trauma and Orthopaedics.

Prioritise diagnosis and treatment by:

- Working across the Dorset system and with other NHS providers to offer patients who are waiting a long time, alternative locations for treatment to reduce their length of wait. Including supporting patients to access a new national network for long waiters.
- Ensuring waiting list management consistently follows national clinical prioritisation frameworks.
- Supporting the development of investment plans that lay the foundations for further expansion of capacity through CDCs in 2023/24 and 2024/25.
- Ongoing participation in Dorset Endoscopy Network and the establishment of a long-term solution for endoscopy capacity at UHD. Including expanding capacity at Wimborne, 6 day working in Endoscopy and provision of out of hours/on call endoscopy nursing at the RBH site.
- Developing the trauma pathway.
- Addressing workforce challenges in cardiac services related to echocardiogram capacity through recruitment of Physiologists.
- Undertaking clinically led validation of our elective waiting lists so that they are accurate, organised and prioritised in a way which seeks to engage and empower patients in decision making about their care. Our validation programme will take a digital-first approach and learning from this experience will be transferred to develop further ways of reaching out to patients who are clinically vulnerable and promote self-management.
- Through our access policies we will set the expectation of three-monthly reviews for patients waiting over 78 weeks.
- Moving to a single Patient Administration System (PAS) for UHD.

- Continuing to develop our approach to population health management in relation to elective care, building on the use of data in the DiiS to better understand variations in access, outcomes and experience of treatment and develop detailed clinical and operational action plans to address health inequalities.
- Continuing our focus on reducing interventions identified as of lower clinical value in deliver of the Evidence Based Interventions programme across the Dorset system.

Transform the way we provide elective care by:

- Delivery of our transformation programmes across Theatres and Outpatient services.
- Developing options to support networked MSK/Orthopaedic services and protect in-patient elective capacity.
- Implementing the Medisight Ophthalmology EPR

Providing better information and support to patients by:

- Empowering patients while they are on the elective pathway by giving them the opportunity to access information specific to a range of conditions through the My Planned Care platform, to enable a better understanding of supporting their own health while on the waiting list and how long they may be waiting.
- Enhancing and embedding culturally competent personalised care planning and approaches to support patients to ‘wait well’.
- Mitigating against digital exclusion by continuing to offer face to face care to patients who cannot use remote services. Our approach to addressing health inequalities will include an assessment of who is accessing face to face/telephone/video consultations broken down by age, ethnicity, IMD, disability status and other population characteristics.

Assumptions

As a result of these actions, we are committed to deliver the following performance, to:

- Deliver 95% of 19/20 day case activity, 90% of 19/20 elective activity and 96% of Outpatient first attendances in 22/23.
- Eliminate 104 week waits by July 2022 except for Orthodontic waits which we aim to eliminate by end October 2022.
- Eliminate over 78 week waits by April 2023, in year reducing the number of 78 week waits and introducing 3 monthly reviews.
- Reduce 52 week waits by March 2023.
- Reduce OPFU by March 2023 to 85%.
- Use released OPFU capacity to reduce clock starts and/or increase clock stops, with the impact of reducing the total waiting. This capacity will also be redirected to support the organisational response to surges in demand due to seasonal pressures or COVID.

- Expand PIFU to all major specialties, moving or discharging 5% of all outpatient to PIFU by March 2023.
- Deliver 16 specialties advice request including A&G, per 100 outpatient first attendance by March 23 across the Dorset system.
- Continue to offer video and telephone consultation for outpatient services with a minimum of 25% taking place by this route.
- Reduce diagnostic over 6-week waits to less than 5%
- Increase diagnostic activity to a minimum of 100% of pre-pandemic levels across 2022/23

Risks and Issues

- People recovery - a key risk to elective recovery is the workforce capacity. We have a high number of vacancies and a fatigued workforce, which extends beyond frontline staff.
- Theatre capacity - we have insufficient internal capacity to meet the demand for routine surgery and successful delivery of elective recovery will rely upon access to additional independent sector capacity.
- Funding – our ability to earn additional elective funding to support the elective plan is based on delivery against an equivalent value-based activity target of 104% of the 2019/20 baseline.
- Patient compliance and public anxiety

Further details of elective care are included within individual specialty plans.

4.6 Cancer

During the subsequent phases of the pandemic the Trust continued to work as an integral part of the Dorset Cancer Partnership (DCP) and Wessex Care Alliance (WCA) to ensure cancer treatment where clinically safe to do so was prioritised.

Progress made during 2021/22

Some of the key achievements are as follows:

- The Dorset bowel screening programme was the first in the South West to recover the invitation back log for Faecal Immunochemical Testing (FIT) and successfully extended screening to people over 56 years of age in May 2021.
- Implementation of teledermatology for all routine referrals for suspected skin cancer, with the introduction of Advice & Guidance in dermatology and a requirement to attach photos which meet agreed quality standards.
- The reintroduction of one-stop prostate clinics.
- Establishment of Cancer Support worker role within specific tumour sites.

Key challenges

Whilst at the height of the pandemic there was a significant drop in referrals the Trust has now regained referral numbers to meet pre-pandemic levels. Sustained increase in referral numbers in several specialties has proved challenging in

colorectal, breast, head and neck and skin. It is expected nationally that levels of demand will rise in 2022/23 as people with cancer symptoms are encouraged to come forward.

Capacity to manage areas of high demand has been impacted by diagnostic and treatment capacity as well as the availability of specialist and administrative workforce.

Work with Wessex Cancer Hub has been stood down, whilst use of the independent sector for cancer treatments is still available.

Cancer Improvement Programme

In 2021/22 the Dorset Cancer Partnership launched a Cancer Recovery and Improvement Programme to address identified challenges that were holding the Partnership back from achieving its ambitions for cancer services as well as delivering transformation opportunities to support improvement.

Key deliverables of the programme are to:

- Establish a phased, outcome-oriented roadmap for the delivery of recovery and improvement across Dorset's seven priority tumour sites: Lower GI, Head and Neck, Gynaecology, Upper GI, Urology, Skin and Breast, and ensure timed pathway milestones are met.
- Accelerate progression of high-level demand and capacity analysis for each of the priority tumour sites.
- Implement a more consistent approach to cancer pathway processes and design, with a focus on the triage of patients to support patients to receive congruous service and outcomes across Dorset.
- Improve performance in a range of operational targets across the partnership.
- Embed DCP/WCA cancer dashboard into specialty governance structures to monitor progress and identify unwarranted variation.

The programme is underpinned by the three cross cutting themes of addressing health inequalities, digital transformation and innovation and getting the basics right.

We are also committed make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower. Delivery of the improvement programme in partnership with the Wessex Cancer Alliance aims to improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard.

Actions

In 2022/23 we will:

Ensure there is **sufficient diagnostic and treatment capacity** to meet recovering levels of demand by:

- Working with public health commissioning teams to restore all cancer screening programmes through enhancing current clinical delivery models, including the utilisation of the Outpatient Assessment Centre in the Dorset Health Village for breast screening.
- Streamlining all cancer pathways across UHD to ensure equity of access for patients.

- Improving data sharing with primary care on faecal immunochemical test (FIT) requests and patient information on FIT to support an increase in the proportion of patients referred with suspected lower GI cancer accompanied by a FIT.
- Introducing precision point technology for prostate biopsies.
- Optimising the uptake of innovations including delivering the Cytosponge pilot, and colon capsule endoscopy, to support effective clinical prioritisation for diagnostics
- Increasing triage capacity by provision of additional or high flow clinics to clear the backlog of referrals and the introduction of e-triage, to improve performance against timed pathway milestones.
- Implementing additional one-stop triple assessment clinics for suspected breast and gynaecology cancers.
- Increasing local anaesthetic clinic capacity for ultrasound and hysteroscopies.
- Implementing personalised patient stratified follow up pathways for breast, bowel, testicular and prostate cancers implemented June 2022, followed by endometrial and haematology by March 2023.
- Streamlining access for patients with vague lump symptoms through implementing a Lymph Node Pathway.
- Reintroducing video microscopy in head and neck services.
- Increasing Robotic Assisted Radical Prostetectomy capacity through the procurement of an Xi Robot to reduce operative times for cystectomy.
- Implementing nurse-led scope clinics for low risk head and neck cancer referrals.
- Implementing standardised booking processes to optimise the utilisation of clinic slots for urgent referrals.
- Bringing forward staging CT scans following diagnosis at endoscopy for upper GI cancers.
- Delivering on our ongoing commitment to the clinical validation and prioritisation programme, including through our access policies we will set the expectation of at least weekly reviews for those waiting longer than 62 days on a cancer pathway.

Ensure there is **sufficient workforce capacity** to meet recovering levels of demand by:

- Increasing the recruitment and retention of advanced nurse practitioners, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce in partnership with WCA.
- Recruiting additional trainee consultant radiographers across Dorset.
- Implementing recruitment and retentions plans to address vacancy gaps in admissions and outpatient booking teams and specialist clinical posts.
- Identifying variation in clinical skill mix and aligning workforce capacity to areas of need.

Enhance **availability of data** to target variation by:

- Completing the development of an early detection dashboard which will enable forecasting of cancer

incidence and staging at diagnosis, with ability to analyse data for variation according to demographics and deprivation.
- Enhancing the existing Cancer health inequalities dashboard available through the DiiS to identify inequalities for specific groups that are identified as having (or at risk of having) poorer outcomes.
- Supporting the delivery of the South West Health Inequalities strategy for screening programmes, which will include breast screening.
- Launching Dorset Care Record (DCR) MyDCR patient portal.

Risks and issues

Key risks

- Continued increase in demand in certain tumour sites impacting on capacity
- Patients declining diagnostic interventions due to ongoing concerns around COVID-19.
- Capacity levels reduced due to on-going COVID restrictions
- Staffing skills and infrastructure to meet the increases in demand, especially in key diagnostic areas: radiology, pathology, radiotherapy
- Capacity in IT infrastructure to support developments both in remote monitoring and protocol/AI driven triage.

As many pathways are reliant on more than one Provider, these risks are not just intra-Trust but inter-Trust

Assumptions

As a result of these actions, we are committed to deliver the following performance:

- To return the number of people waiting for longer than 62 days (including 104 backstops) to the level we saw in February 2020 by March 2023.
- Deliver the number of treatments required to address the shortfall in the number of first definitive treatments (31 day) in all quarters.
- Recover the backlog in breast cancer screening to meet national standards (36-month cycle) by August 2022.
- Recover the Faster Diagnosis Standard to the levels seen in Q2 2021/22 by Q2 2022/23
- To deliver at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones through delivery of the cancer improvement plan.

4.7 Living with COVID

The coronavirus pandemic presented an unprecedented challenge for the National Health Service in response to record demands for care, whilst protecting the health of

patients and staff. Vaccines have enabled the gradual and safe removal of restrictions on everyday life over the past year and will remain at the heart of the Government's approach to living with the virus in the future.

The NHS, with the help of volunteers, has delivered one of the largest vaccination programmes in history. Vaccines and other pharmaceutical interventions will continue to form the first line of defence and the Government has recently accepted the JCVI recommendation to offer an additional booster to all adults aged over 75, all residents in care homes for older adults, and all over 12s who are immunosuppressed.

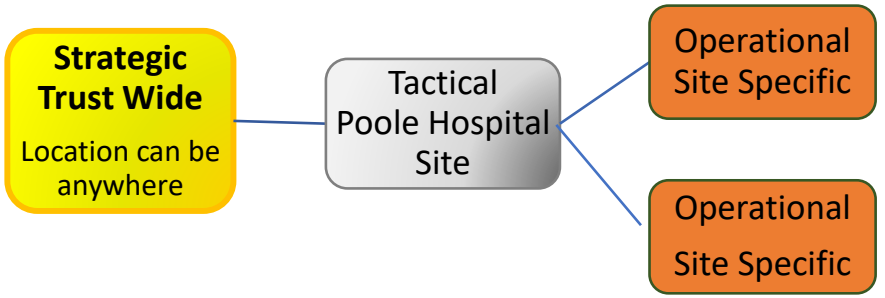
The Government will continue to be guided by the JCVI on future vaccine programmes and UHD will respond to the pandemic in line with the latest government advice. To support us with this response we have the following procedures in place.

Incident Management

We have a well-established incident management (operational, tactical, strategic) response model which can be escalated as required. In line with current NHS incident levels, our current arrangements remain responsive to the ongoing requirements of incident management, internal and external escalation, receipt of national guidance and requests for information.

Since merger in October 2020, progression has been made towards the integration of the organisation, services merging and managers, matrons and other staff working across both sites; this has led to much closer working and knowledge of both sites by all senior staff.

Poole Hospital site is the Trust's Headquarters and has become the primary Incident Coordination site as follows:



The Bournemouth Hospital site will remain as a back up venue and will continue to be maintained.

Preparations for any future potential surge requirements for COVID patients

Capacity

Our current operational capacity plan is being updated to take account of the current and estimated future prevalence of COVID in the local community and to address continued operational pressures.

Bed Modelling

The advent of COVID19 and the resultant IPC and social distancing measures reduced our bed capacity significantly, however as the Health Service moves to 'Living with Covid' it is anticipated the majority of closed IPC beds will be reopened permanently. In addition, reconfiguration of areas and pathways (e.g. Blue ITU) is planned to manage the risk of reduced core bed availability. Our bed capacity modelling will consider a significantly reduced Covid bed base scenario. Planning for COVID activity will remain iterative and will be based on public health advice in relation to community incidence and vaccination impact.

Internal bed model based assumptions:

- 88% max occupancy (to allow for swabbing, distancing and other related pathway challenges)
- 0% growth on 19/20 non elective activity
- Elective activity assumptions that meet the national recovery trajectory requirements
- Base model assumes COVID activity will continue to decrease but will allow for fluctuations in community incidence/hospital admission rate.

Capacity becomes substantially more challenging from the autumn onwards and this will be considered during the winter planning round. Further mitigations are in development to offset capacity gaps which include;

- Review of speciality pathways and cross site bed capacity demands for opportunities to optimise bed capacity across UHD
- Alternative care models which support admission avoidance, Same Day Emergency Care to avoid unnecessary overnight stays and/or reduced Length of Stay across UHD
- Work internally and with Dorset System partners to optimise the Criteria to Reside framework and Home First programme.
- Review and refinement of our UHD-wide escalation (OPEL) plans and associated risk assessments

Critical Care

During 2021/22 circa 10% of COVID admissions required critical care, with most patients requiring respiratory high care. Modelling information on capacity and demand with associated surge modelling allowed for the flexing of critical care capacity to meet expected demand. Surge and escalation plans were in place with critical care networks providing resilience across the network in case of severe demand. Additional beds were created on both sites, providing physically separate areas to safely manage the isolation requirements of c19+ patients.

Both the RBH site and the PHT site are maintaining Covid ICU areas and pathways in addition to Covid escalation plans that have been tried and tested throughout 2021/22. Based on this experience, bed capacity requirements for 2022/23 are around high care rather than ITU beds. Planning therefore has commenced in how to create a high care area to benefit the needs of our patients, whilst providing a safe environment for patients.

During 2022/23 we will continue to provide appropriate isolation for patients with infectious diseases for patients requiring critical care and the needs of elective patients who require HDU support.

We will develop workforce planning and a recruitment strategy to support the workforce of the units and intend to pilot an enhanced recovery area and high care surgical pathways to help preserve the bed base for complex/high risk procedures and emergency care.

In order to make best use of capacity outside of the RBH and PHT sites we will develop a sustainable cover arrangement for general anaesthetic activity at Wimborne Community Hospital and maintain our strong link with local and regional critical care networks.

COVID Testing

Rapid testing:

We have a range of rapid testing equipment on site in dedicated areas :-

- For point of care testing the Directorate have transitioned to the new Samba2 assay with a shorter run time.
- The Trust has received increased allocation of Genexpert reagents that have supported wider use of this assay including providing resilience during down time of alternative platforms
- The Genexpert multiplex assay is now available for Covid, Flu A, Flu B and RSV testing to allow differentiation of specific viruses in patients with nonspecific symptoms
- Currently awaiting delivery of additional 2 x 8 module Genexpert analyser for out of hours multiplex testing

Non-rapid Testing:

We also have a range of non-rapid testing on site.

- Capacity has been increased on the Step One Plus platform at Poole to 180 swabs per day. This has reduced Poole's reliance on referred work to Bristol and Porton Down giving a faster turnaround. However, staffing for the team performing the assay is still at the minimum required to run a seven day service with insufficient resilience to cope with unplanned absences
- One Dorset Pathology are seeking NHSI support for implementation of a Roche 6800 analyser to be installed at DCH which would have the capacity to process all non-rapid testing and referrals generated in the county

Vaccination

In 2020 and 2021, the Trust delivered a vaccination programme for UHD staff and the wider health and social care workforce. In total we vaccinated around 35,000 staff using out-patient accommodation and co-opting a wide range of clinical and non-clinical staff to deliver this.

Working with system partners, the Trust are in a position to respond to any further national guidance regarding boosters for staff, the wider health and social care workforce and at-risk patients as and when the guidance becomes available.

Infection Prevention and Control (IPC) - COVID Actions

COVID-19 Specific

- Complete post infection review reports for all COVID-19 cases acquired within the Trust (after day 8) excluding those identified within an outbreak.
- Complete a review of all outbreaks following the agreed Trust template developing a thematic learning plan for the Trust building upon the report recommendations from the 2020/2021 findings
- Set up and establish a COVID-19 dedicated pathway for patients on both sites with clear guidance for admissions into their speciality wards. This will include clear guidance for how to manage increasing prevalence, healthcare acquired cases and triggers to review the safety of the pathways in each area.
- Support the development of a Respiratory High Care Unit including the design and functioning of the ward from an IPC perspective.
- Incorporate learning from COVID-19 into current IPC policies to support the development of pathways into the Trust.
- Risk assess requirements for weekend cover for IPC across UHD to ensure that a plan is in place to deliver the Trusts requirements for IPC in the presence of any increased peaks or outbreaks of COVID-19.

Other IPC Actions in 2022/23

- **Surveillance -** Fully integrate ICNET (Electronic surveillance tool) into reporting and managing of patients with alert organisms. Explore the benefits of using this system with CMST to support out of hours IPC actions Incorporating a surgical feed to enable monitoring of surgical site infections.. Review the Trust wide monitoring and recoding of post procedure infections to ensure that there is an accurate understanding of this burden on patients and the Trust.
- **Surveillance –** Ensure that the Trust is an active member in the collaborative projects across the South West and UK looking into the increasing burden of Clostridioides difficile, MSSA and E. coli upon patients. Use the learning and actions from these events to reduce the health care associated cases and support the reducing of community associated cases.
- **Cleaning and Decontamination.** Set up Trust wide Decontamination group. Continue to support the implementation of the new Healthcare Cleanliness Standards. Work with the Facilities senior management teams to continue monitoring the standards of cleanliness within the Trust.
- **Equipment** Support the introduction of a Trust wide Bedframe and Mattress management system including the ability to offer a higher standard of bed and mattress cleaning systems.
- **New builds/ modifications of existing structure -** Continue to work with organisation to ensure that all new builds and modifications are planned and delivered in a safe way for patients and staff. This will cover not only the design concept but also ensuring a risk assessment takes place to review impact on the clinical environment prior to building work commencing following the IPC in the built environment policy.
- **Staffing -** Merge the two IPC Teams into 1 to ensure resilience and support available for the Trust establishing key roles for all members of the team and explore how the Team can work cross site to increase resilience.
- **Learning** Complete programme of listening events and debrief for team members to ensure all members are fully supported.
- **Training -** Deliver training and education programme for IPC Champions across UHD to establish a Trust Wide network with the potential to support the IPC Team during periods of extreme pressure. Ensure all new joiners to the IPC Team have access to training and that existing staff get the opportunity and time to refresh skills and knowledge in areas that have not had focus due to the high demand of COVID-19.
- **Policy -** Risk assess all IPC UHD policies alongside Dorset ICS IPC policies to create a plan to review, update and merge policies based upon risk. The aim would be for the creation of Dorset wide policies.

4.8 Tackling Health Inequalities

Covid-19 has shone a light on inequalities and highlighted the urgent need to strengthen action to prevent and manage ill health in deprived and ethnic minority communities. Narrowing the gap in health inequalities and improving health outcomes is a golden thread woven throughout all aspects of our plan.

In 2022/23 we will strengthen our use of population health management to narrow the gap in health inequalities and improve health outcomes. We aim to proactively identify the health inequalities of our population to inform service design and policy development.

We will build upon the strong foundations provided by the Dorset Intelligence and Insight Service (DiiS) population health management (PHM) tools, which give access to comprehensive, good quality data and linked data sets from many care settings including acute care, primary care, mental health and social care.

Our approach will be to use this data to identify the needs of our communities experiencing inequalities in access, experience and outcomes in relation to their health, so that we can respond with tailored strategies for addressing inequalities and track the impact of these strategies. To support this, we will continue to improve data collection on ethnicity within the waiting list minimum data set (WLMDS).

We will work collaboratively across the Dorset ICS to adopt the Core20PLUS5 approach and to deliver the ICS Integrated Care Strategy. In doing so, we will made specific consideration of Black and minority ethnic populations and the bottom 20% by IMD for clinically prioritised cohorts.

Building on the work undertaken in 2021/22 to evaluate the impact of elective recovery plans on addressing pre-pandemic

and pandemic-related disparities in waiting lists we will continue to spread the learning to date to other prioritised cohorts.

Our strategy will relate to addressing health inequalities for both patients and staff. Our Equality, Diversity and Inclusion Group and Healthy Working Lives Group will be asked to set out its priorities in tackling health inequalities as they directly relate to staff and to review the strategy to ensure activities are viewed through a health inequalities lens.

Accountability for health inequalities will be assured through our Board performance reporting framework. We will move towards outcome reporting, breaking down performance reports by patient ethnicity and IMD quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations. In 2022/23 we will ensure that an assessment is made of the South West regional health inequalities dashboard to allow for measurement, assurance and regular oversight by the Board

of the impacts achieved in closing the gap on health inequalities.

We will strengthen our governance arrangements by establishing a trust-wide Health Inequalities Group, with appropriate connection to the Board through the Finance and Performance Committee, to lead this work and develop an overarching plan for the prevention of ill health. A designated Senior Responsible Officer at Executive level will have responsibility for oversight. Dedicated operational leadership and resources, including a programme lead and clinical champion will be identified to support the programme.

To reflect our position as one of the biggest employers in Dorset, we will consider adoption of the Anchor Institute approach and be an active member of the Dorset Anchor Institution's Network.

In 2022/23 we will also;

- Review our current patient engagement strategy to ensure we optimise how we understand our communities and the way in which they experience our services through personalised culturally competent approaches to clinical and operational management including participatory community engagement.
- Evaluate the Trust's approach to Equality and Health Inequalities Impact Assessment to ensure its alignment with NHS best practice.
- Support staff to access training on population health management and health inequalities, including the development of technical and analytical capability within the Performance and Business Intelligence service.

5. Transformation, Capital Development and Sustainability

5.1 Overview

Dorset has been on its ambitious transformations journey since the Clinical Services Review (CSR) completed in 2017 and set the clinical strategy to best meet our populations needs. For UHD two major capital developments are underway to support the reconfiguration of services into the Planned Hospital site at Poole and the Emergency Hospital site at Bournemouth.

UHD has been awarded STP Wave 1 funding of £201m to establish the BEACH building (Births, Emergency care, And, Critical care and child Health) and additional capital to develop a new theatre block at Pole Hospital. A Strategic Outline Case has also been approved for £205m from the New Hospitals Programme to establish the other reconfigured services required to meet the planned and emergency care model.

In addition to the ambitious capital schemes the Trust is consolidating the merger of the two legacy organisations, transforming services through improvement & innovation, implementing operational changes and improvements across the care pathway and has been strengthening the partnership working with Bournemouth University.

The strategic plan for UHD over the next five years will see delivery of high quality, safe and sustainable services for the population of Dorset in a modern, fit for purpose estate as detailed in our estates masterplan.

5.2 Estates Development

The UHD estates strategy up to 2026 is well established, with key service reconfigurations in 2024 and 2026 resulting from the major build programmes.

In 2022/2023 significant enabling works will continue to progress the complex capital programme that supports the Acute Reconfiguration. This includes the continuation of the RBH main entrance, demolition of the catering block to make way for the new seven storey block which will house a new catering facility, three new theatres and three new wards, capital works for the movement of antennal to the St Mary's site, enabling works to support the new Macmillan unit on the Christchurch site.

The new Theatre block at Poole Hospital will be completed externally in 2022/23. Work continues in establishing estates quality compliance systems and reducing estates backlog work.

Construction of the One Dorset Pathology Hub on the Royal Bournemouth site is expected to complete by March 2023, with services moving in early 2023/24.

The Capital Expenditure Departmental Limit (CEDL) allocated to Dorset and UHD continues to constrain the backlog and maintenance carried out across all three hospital sites. The Integrated Care System is in the process of agreeing a capital prioritisation process which will allocate CDEL for future years, this may add further pressure to the UHD capital plan should other partners in the system have higher prioritised capital expenditure requirements.

For 2022/2023 the estates capital programme focus is on:

i) Completion of works already in progress, many related to enabling works for reconfiguration.
ii) Essential and backlog reduction maintenance
iii) Planning and preparation of major schemes such as the BEACH (Births, Emergency care, And, Critical care and

child Health) building, Poole Hospital theatres, New Hospitals Programme schemes at the Royal Bournemouth Hospital, Poole Hospital and Christchurch Hospital sites.

5.3 Sustainability- Green UHD Plan

The UHD sustainability strategy aligns with the requirements set out in the NHS national plan, delivering a “Net Zero” national health service.

The Sustainability Strategy, or Green UHD Plan, is built around four levels, these are

- Our vision to provide excellent healthcare
- Our green objectives, healthy lives, healthy community and a healthy environment
- A set of cornerstone targets relating to carbon, clean air, the use of resources, sustainable development goals and staff engagement

Our green plan can be found on: https://www.uhd.nhs.uk/about-us/sustainability#:~:text=University%20Hospitals%20Dorset%20NHS%20Foundation%20Trust%20(UHD)%20has%20launched%20its,NHS%20England's%20carbon%20neutral%20target.

To realise our green plan there are ten areas of activity that cover all the aspects of services within UHD.

- Asset management and utilities
- Use of resources
- Monitoring our carbon and greenhouse gas emissions
- Capital development
- Adaption to climate change
- Our green spaces and biodiversity
- Sustainable models of care
- Travel and logistics,
- Our staff and how they can help with the change

The plan has put the trust on the route to being a net zero organization by 2040 in line with the wider NHS plan. The plan contains a range of measures across the action areas that will be revised regularly as we move along the reduction trajectory.

5.4 Digital Programmes

UHD has a *Best of Breed* approach to deploying systems that meet specific departmental needs and uses messaging and a *portal* based EPR (Graphnet CareCentric) to share information across the Trust and the wider system, via the Dorset Care Record.

The vast majority of our departmental systems send data to EPR and we currently have 5 critical enterprise-wide systems (EDM, Order Comms, EPMA, Dorset Care Record, Radiology PACS) linked to EPR such that the user can launch these systems from within EPR without having to login or find the patient from within that connected system[1]. Work is progressing to deliver another 2 systems within the next 6 months (HICSS (endoscopy and rheumatology) and eNurse Assessment).

All historic paper-based recording of clinical care is now scanned following the inpatient and outpatient event and consequently no “legacy” paper documents are presented to clinicians at the point of care. Graphnet EPR has >180 specific electronic form templates and >300 specific e-forms exist outside of Graphnet EPR for clinical and non-clinical use. It is difficult to find a clinical department that does not use computer-based recording for at least part of their patient interactions and gradually, albeit slowly, the dependency on paper recording is being eroded, particularly in the non-inpatient settings were clinical staff are finding it easier to make this transition.

Over the last 12 months it had become clear that the best of breed/portal approach may be constraining our attempts to improve clinical productivity through digital transformation as it requires clinicians to navigate multiple systems to conduct effective clinical workflow. This would suggest that UHD, in the context of the ICS, needs to consider a new

genre/architecture of clinical information systems to make the next step change in digital services to support clinical safety and efficiency.

Graphnet, our portal provider, as part of the System C alliance, has indicated that although there is no threat to the continuation of our existing portal-based system, the future roadmap for that product is to subsume it within system C EPR which presents a far richer Services Oriented Architecture approach to clinical systems. No decision has been made yet on the UHD strategic digital future given the recently announced national “managed EPR convergence” policy which is still under consideration at Dorset ICS level.

The UHD current plans are to continue with the tactical deployment and completion of in-flight deployments of best of breed systems with as much integration as possible to our existing clinical ecosystem to provide value to our clinical and operational staff in addressing their objectives until such time as we have an overarching Dorset wide architecture, roadmap and programme of delivery. Some key projects are described below, this is not an exhaustive list.

- new theatres departmental system being procured and implemented to support productive theatre initiatives in support of elective care recovery
- Completing deployment of EPMA for inpatient settings
- team based notification in-house development to provide closed loop reporting for results and referrals
- deployment of order comms and results reporting to cardiology and endoscopy
- procurement and deployment of image sharing solution as part of the south-east three diagnostics network
- deployment of a range of digital technology to support outpatient productivity (including online booking platform, voice recognition, robotic process automation, business intelligence tools, workflow enhancement for referral and advice and guidance management)
- replacement of traditional pagers for routine communication with a portable, WiFi connected device allowing immediate communication by instant message, voice and video
- Removal of all unsupported operating systems and applications in line with meeting our DPST requirements

These developments will be underpinned by a systematic rolling stock replacement of all layers of our technical Infrastructure and end-user devices and work to achieve a fully compliant Data Security and Protection Toolkit submission

With support from the UHD Board of Directors, we will be undertaking the detailed design and implementation planning for a single Digital Dorset Shared Service during 2022/23

5.5 Bournemouth University (BU) Partnership Strategy

Our BU-UHD partnership strategy identifies the main areas of focus for the BU-UHD partnership programme:

- strategic alignment – better coordination of strategic objectives
- stimulus for research and innovation – facilitate collaboration and increase research activities
- education and training of future workforce – develop training opportunities and meeting future workforce training needs
- recruit and retain talent – making BU and UHD great places to work
- meeting future challenges – working together to better solve future challenges
- wider private and public partnerships – working closely with other partners

The strategy promotes a “joint by default approach” between the organisations, complementing the existing work and strategies of each individual organisation, enhancing the work that is already done together and developing on both organisations’ strengths.

The jointly agreed work programme identifies the collaborations planned for the year in order to deliver benefits to patients, students, staff, organisations and wider. Key opportunities in the coming year are:

- to collaborate to develop new roles across the hospital and university attracting new talent supported by guidance for creating joint appointments
- to utilise UHD apprenticeship funding to co-design and co-deliver training to support development of our senior leaders and utilising existing talent from across the organisation to train others
- to enable further research to support both improved patient experience and outcomes including 4 Match funded PhDs to develop digital assistive technology for use in breast cancer surgery, new nurse led technology enabled pathways for patients with skin cancer, develop more personalised care for women of advanced maternal age and improve wayfinding in hospital
- to work together to increase the number of non-clinical placements for BU students from a range of faculties at UHD

Both BU and UHD recognise the strength of working more closely together and are committed to this programme in the coming years.

6. Governance, ICS Development and Communications

6.1 Governance and Assurance

University Hospitals Dorset Hospitals recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify and contextualise risk, ensuring that the Trust understands the risks it is prepared to accept in pursuing the Trust's aims and objectives.

The overall aim of the Trust is to achieve a culture where risk management and safety is everyone's business, that there is open and honest recording of risks and a culture that encourages organisation wide learning and risks are continuously identified, assessed and minimised. A culture of ownership and responsibility for risk management is fostered and supported throughout the organisation.

The Trust Risk Management Strategy sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds. The strategy supports the delivery of;

- Devolved decision making and accountability for the management of risk throughout the organisation; from the point of delivery to the Board.
- Promoting a culture of assurance, monitoring, and improvement, ensuring risks to the delivery of Trust strategic objectives are well understood.
- Supporting patients, carers, and other stakeholders through the management of risks to patient safety, patient experience, and service delivery.
- Refining processes and systems to ensure engagement in risk management is efficient and effective, enabling good decision making through robust reporting to relevant decision making groups and scrutiny groups.
- Supporting the Trust Board, commissioners, and other key stakeholders in receiving and providing assurance that the Trust understands its risk profile and is working to mitigate key risks in appropriate and timely ways.

The Trust Board of directors recognise that Risk Management is an integral part of the Trust's quality, governance, and performance management processes. The Board, with support from its committees has ensured a robust system of risk management is effectively maintained whereby risk management is embedded across the Trust through policy, strategy, and plans.

The Trust manages risks by:

- Undertaking an annual assessment of the organisation's objectives and identifying the principal risks to achieving

those objectives (Board Assurance Framework (BAF) risks). The BAF is a key mechanism to reinforce the strategic focus of the board and better manage risk.

- Regular monitoring of the effectiveness of the Board Assurance Framework by the Trust's Board and the Audit Committee.
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified and the controls in place to mitigate them
- Regular monitoring and review of the risk register and risk appetite ensuring the risks are managed effectively and at the appropriate level within the organisation and escalated where appropriate.
- Integrating risk management into business planning, quality improvement and cost improvement planning processes, ensuring that objectives that are set across the organisation with plans to manage risk in accordance with quality impact assessment and risk assessment procedures.

As well as the Board itself, all Board committees have defined responsibilities to oversee relevant risks

This is further supported by risks being reviewed by defined groups through the organisation including:

- Trust Clinical Governance Group
- Care Group and Directorate Risk and Governance Groups

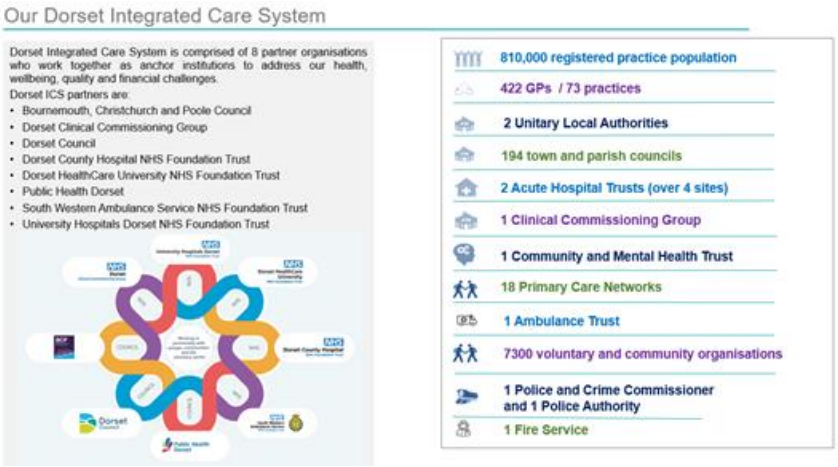
6.2 Integrated Care System (ICS) Development

The NHS Long Term Plan confirmed that all parts of England would be served by an integrated care system (ICS) by 1st July 2022. At this point Dorset CCG functions will transfer to Dorset ICS and the governance arrangements of a Dorset Integrated Care Board, Provider Collaborative and Integrated Care Partnership will be established.

Dorset ICS will have four key functions:

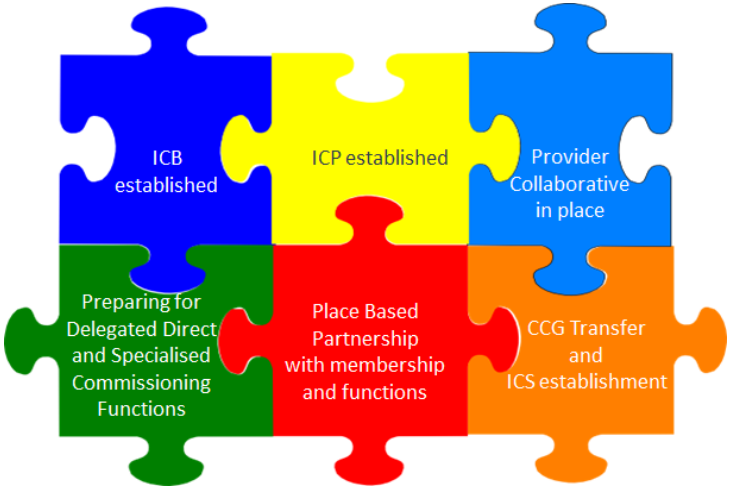
- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- supporting broader social and economic development.

Health needs and localised services will be determined in part through Place-based partnerships for the Dorset and PCT council boundaries. See below for ICS membership.



All the organisations operating within the Dorset ICS recognise that their effectiveness is dependent on the connections with other organisations across the health and care system, which in turn significantly impacts on the outcomes and experience of our patients. UHD has always had a strong commitment to partnership working, with its vision being “To positively transform our health and care services as part of the Dorset Integrated Care System”.

The main changes on day one of the new ICS are outlined below with new leadership and structures in place by July 1st. It is likely a key focus of the new ICS will be health inequalities and population health management and UHD is working closely with ICS members on these issues.



6.3 Communications and Engagement

The University Hospitals Dorset communications strategy and plan will support the 2022/23 priorities and operational plan. This will be done hand in hand with our UHD values that will underpin our communications as they underpin everything the Trust does.

Our communications team, working with colleagues across the Trust, will focus efforts on communicating with staff and the public to ensure they are kept in touch with what’s happening at UHD and to share any important health messages.

Our communications plan will be developed to be multi-channel. We need to ensure that all our communication

reaches the correct audiences at the right time and by the right channel. This means we need to explore all forms of communications, from digital, to social media, to traditional posters and signposts on location.

Successes that we will build on include our website (www.uhd.nhs.uk); twice weekly email bulletin; CEO videos (published on our You Tube channel), online staff briefings; the Brief – monthly staff digital and printed publication: screensavers; and social media channels (Twitter, Facebook, Instagram, Linked In).

We have also rolled out a staff app which helps frontline staff who traditionally haven't had access to our communications through desktops. Over 7,600 staff have downloaded this onto their person devices.

We also publish Together magazine three times a year which is sent to all members of our foundation trust.

We have built up very strong media relations both locally and nationally and will continue to work closely with the media as appropriate.

Our key messages will include:

Health, wellbeing and Covid-recovery

We will ensure that all staff have easy access to information to signpost them to all that the Trust has on offer to support their health and wellbeing. Working closely with colleagues in Occupational Health and Organisational Development, we will highlight how we reward and celebrate our staff and also what support we offer for staff who are struggling for whatever reason.

Promoting benefits of our transformation

Recent public engagement events have highlighted that there is still a lot of public misunderstanding/mistrust around the future reconfiguration plans for our hospitals. There is also a lot of misinformation about benefits to patients around the changes. Working with our clinical colleagues, we need to create a new campaign that updates the Clinical Services Review to the here and now. We have the possibility to start holding public events again and these could be used to promote the benefits and answer any queries people may have.

Recruitment and retention

We will promote the benefits of working across our Trust in the many varied roles available. This will be based on the benefits of our new university hospital trust status, our career development possibilities and our location.

Champion Equality, Diversity and Inclusion

Need to ensure we boost the support communications gives to colleagues across the trust, celebrating success and promoting and highlighting the work of the staff networks. This will include encouraging attendance at events and promoting any annual events and diversity calendar.

Promotion of Green UHD strategy and plan

Working with our transformation teams, we shall promote the Green UHD strategy and plan. This will include encouraging colleagues to take steps themselves as well as celebrating successes around the Trust. Will be tied in with the travel plan to help encourage more colleagues to seek alternative transportation to work than single car travel.

Working collaboratively

The UHD communications team works very closely with partners across the Our Dorset Integrated Care System (ICS). The pandemic brought us closer together and we will continue this. Our work together will be focussed on joint resilience and also on addressing the health inequalities of our region.

Preventing inappropriate attendance at ED

Working with the Dorset CCG (and in future Dorset NHS) and with the local media and across our social media channels, we have produced several campaigns focussing on where the best place to go for care is. We will continue to do this to ensure that our ED can provide the best possible care for those who need it the most in a timely fashion. We will work with our partners to showcase the alternatives as well as reminding the public to ensure they don’t ignore symptoms but get them seen to.

Governor partnership

Our communications team is closely linked to our Governors though our membership of the Membership Engagement Group. We work very closely with governors on public engagement with listening events; understanding health talks and through our monthly members newsletter and our publication Together.

7. Finance

The national planning guidance for 2022/23 was written at a time when the NHS was operating within a Level 4 National Incident in response to the emergence of the Omicron variant. Despite this, it was felt important to provide certainty and clarity where possible, including setting out the priorities and financial arrangements for the whole of 2022/23. It is recognised however that these will need to be kept under review.

The objectives set out within the planning guidance together with the accompanying financial allocations are based on a scenario where COVID-19 returns to a low level. COVID funding has been reduced significantly, with this transferred into the national Elective Recovery Fund. The assumption is that significant progress can be made in the first part of the new financial year in restoring services and reducing the COVID backlogs.

Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who are medically ready for discharge. Within the Trust, COVID admissions are increasing daily; both Emergency departments continue to operate under extreme (Level 4) pressures; and we continue to care for over 200 patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate at Operational Pressures Escalation Level (OPEL) 4 with bed occupancy frequently exceeding 100%.

Operating under this pressure requires a relentless focus from all teams to ensure patients receive safe care. Having to operate under this pressure for such a sustained period has obviated the Trusts ability to progress transformation and efficiency schemes at pace. This has limited the Trusts ability to improve productivity and reduce expenditure and when compounded with the significant workforce challenges and reduced COVID funding, makes it incredibly difficult to set a balanced budget.

Revenue

Considerable financial planning and detailed financial modelling has been undertaken within the Trust. This reflects the national planning guidance together with the agreements reached within the Integrated Care System in relation to the distribution of funding across partner NHS organisations. The outcome of this is an expected budget deficit of £32.2 million, within the expected Dorset ICS aggregate deficit of £76.3 million (inclusive of South Western Ambulance Service). This reflects considerable inflation costs above the funding received, the inability to exit specific COVID costs, an expected clawback of Elective Recovery Funding and the

sustained operational and workforce pressures highlighted above.

In addition to this significant deficit, a number of financial risks remain which could, if unmitigated, increase this deficit further. These include:

- Cost Improvement Plans currently amount to £6 million against the target of £14 million, representing a risk of £8 million.
- Pay costs have been budgeted based on the substantive cost, with only a small amount budgeted for the premium cost of agency cover. If the current agency expenditure run rate continues there is an additional risk of up to £6 million.
- Non-NHS income budgets have been returned to pre-COVID levels consistent with the national planning guidance. This represents a risk of up to £2 million if actual income does not recover in full with effect from 1 April.
- Expenditure of £10 million (off-set with dedicated funding of £10 million) has been included to cover the expected ongoing COVID-19 costs. However, costs may exceed this level if not controlled or if COVID related admissions continue to rise.

These risks, together with the wider financial governance procedures will be managed through the Trust Management Group (supported by the Financial Planning Group) and assured by the Finance and Performance Committee and ultimately the Board.

Capital

The Trust has a comprehensive medium-term capital programme, developed as part of the acute reconfiguration business case and fully aligned to the outcome of the Dorset Clinical Services Review.

This very significant and ambitious programme totals £0.45 billion over the coming four years with budgeted spend of £122 million during 2022/23 comprising three key elements:

1. Estates Development (section 5.2 above);
2. Digital Transformation (section 5.4 above); and
3. Medical Equipment replacement programme.

This programme sits within the aggregate Dorset ICS capital programme which lives within the ICS capital allocation. However, several risks remain within the Trusts capital programme including:

- The capital budget includes a 20% slippage assumption and whilst this has been allocated at scheme level, there remains a risk that this will not be achieved resulting in a capital overspend.
- A significant number of priority schemes have been removed from the programme due to affordability within

the ICS capital allocation. There is a risk that these will become urgent and unavoidable requiring in year expenditure to address.

- The New Hospitals Programme schemes totalling £15 million would impact upon the critical path for the Trusts wider reconfiguration programme if not progressed, and therefore if early enabling funding is not secured, there is a risk that the Trust (and therefore the ICS) will breach its capital allocation unless alternative mitigations can be identified.

The Trust has a strong track record of successfully managing its capital budget and this will remain a focus through the Trust Management Group (supported by the Capital Management Group) and assured by the Finance and Performance Committee and ultimately the Board.

Cash

The trust continues to hold a significant cash balance which has been strategically built up over many years and is fully committed, supporting the medium-term capital programme and specifically the unfunded elements of the Dorset Clinical Services Review acute reconfiguration programme.

However, this will be materially depleted if the Trust cannot mitigate the expected revenue deficit, resulting in a requirement to borrow cash in future years.

2022/23 Financial Priorities

The Trust's absolute priority during 2022/23 is to recover the projected revenue deficit thereby mitigating the strategic implications of depleting its cash reserves.

The Trusts approach will be as set out in section 1 above, with an absolute focus on the following key priorities;

- Emergency Care Flow
- Elective Care Productivity
- Sustainable Workforce

In addition to delivering direct financial improvements, making progress in these areas will release clinical and management capacity to focus on further quality improvement, thereby improving productivity and efficiency and reducing waste.

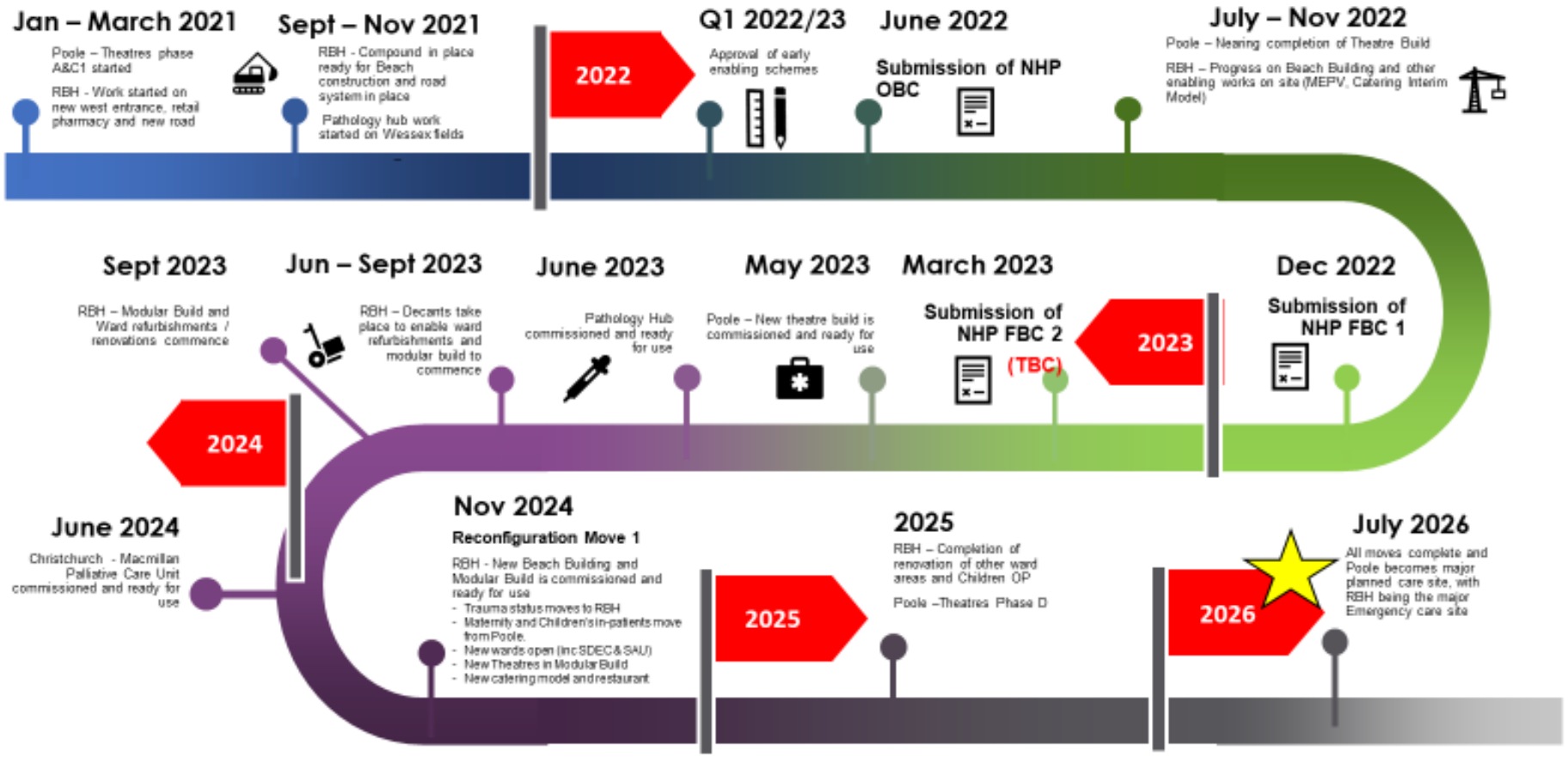
This recovery plan will be underpinned by strong financial governance and control, both within the Trust and across the ICS.

This approach aligns with the wider ICS recovery plan which focuses on:

- Transforming the Urgent and Emergency Care pathway, with a focus on appropriate and timely discharge;
- Recovering the productivity that has been lost through the pandemic;
- Reducing reliance upon premium cost agency staffing; and
- Seeking to remove specific COVID expenditure as we learn to live with COVID.

In addition, the Trust will work with ICS partners to develop a comprehensive medium term financial strategy following receipt of the 2023/24 and 2024/25 revenue allocations which are expected to be published before 30 September

Appendix A – Reconfiguration Roadmap



Transformation Roadmap

East Reconfiguration Detailed Build Roadmap 2022 onwards *Version 1.1*

March 2022

Please Note: Dates Are Indicative

Appendix B – Speciality Level Plans

Appendix 1 – Introduction Section

Introduction - Our Priorities

University Hospital Dorset's (UHD) Annual Operating Plan sets out a significant programme of work for an organisation just 18 months old. The plan sits within the Dorset Integrated Care System plans and within some of the most challenging times the NHS and Social Care have ever faced.

Our multi-year strategy is based on our mission to provide excellent healthcare and to be a great place to work, now and for future generations. We have a once in a generation opportunity to transform our services and 2022/23 will be a cruicial year to re-establish services and re-focus on delivery of excellent care.

As part of our re-focus we have identified the key drivers and areas that have greatest impact on our services. From this a programme-based approach is being developed, focussing on the three most critical areas:

- Emergency care and hospital flow
- Maximising elective care
- Investing in our workforce

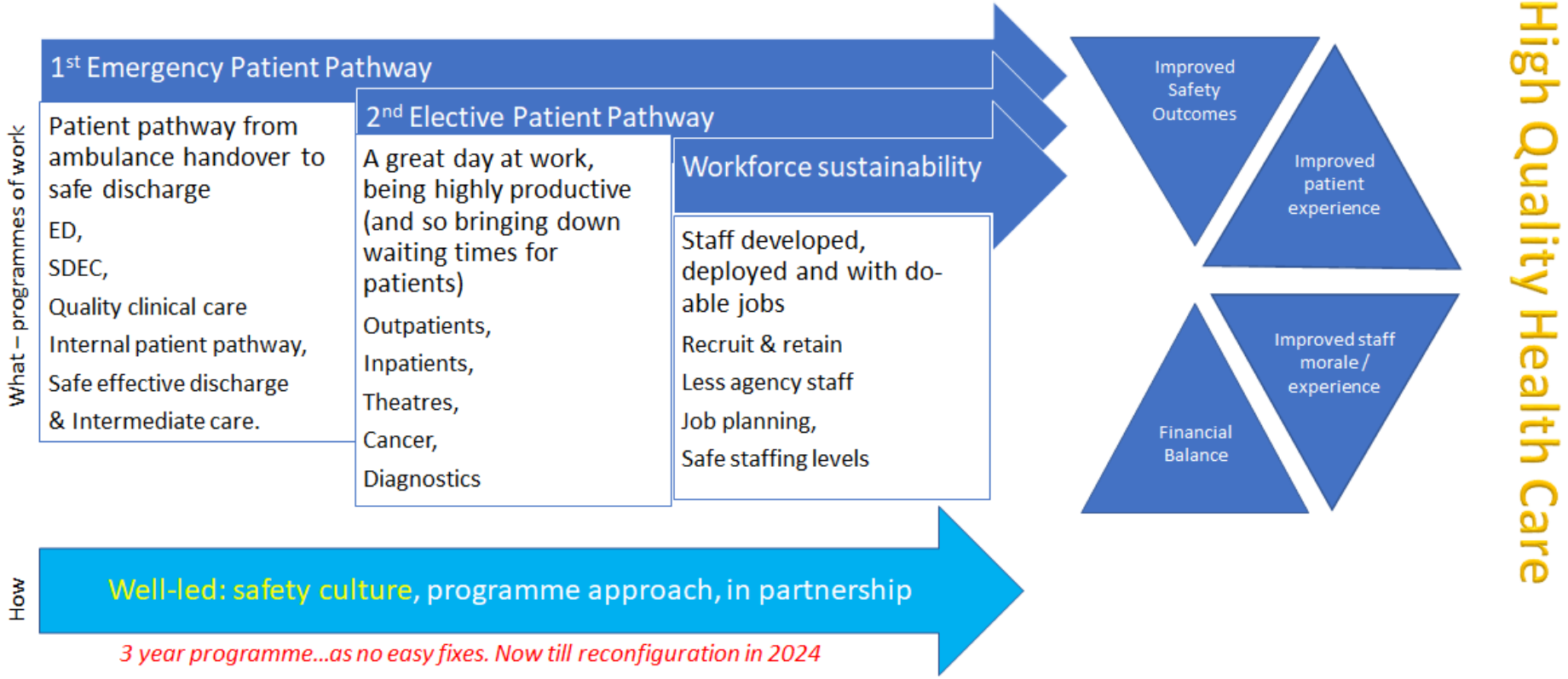
No single one of these priorities will enable us to provide great care, better outcomes for our patients, motivated teams and timely access to care on their own. Together, they unlock far wider benefits throughout our hospitals and for all our staff and patients, and form key parts of our wider annual objectives for 22/23.

For example, improving our emergency care pathways and the experience these patients have will mean fewer elective cancellations due to overwhelming operational pressures.

Our patients rightly expect to receive timely planned care – and we all want to provide this. By maximising our teams, facilities and new technology, we can see more patients for their scheduled care, helping to see patients sooner. This priority is paramount in addressing the numbers of patients on our waiting lists as a consequence of the Covid-19 pandemic.

These achievements will mean little if our workforce is not supported to thrive, develop and grow as we bring in new talent, and keep hold on to those colleagues whose contributions are immeasurable. Our goal is to support and develop all staff in order to meet our priorities for our patients, and ensure being part of TeamUHD is something we all feel and benefit from each day.

The three priorities work together to achieve these outcomes (TO BE REPLACED)



Our priorities set out at high level what we are trying to achieve. The following pages describe how we will achieve them.

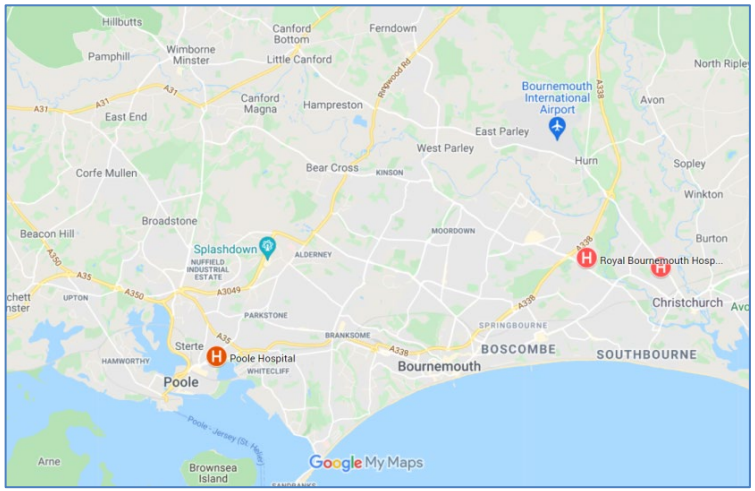
This is an approach that puts a safety and learning culture at the centre of how we deliver care and our major change programmes. This means being a well-led organisation, with leadership expected of all staff, with the empowerment and drive for continual improvement in every service. How we go about delivering the three priorities will be as important as selecting and delivering the priority itself. Only by doing the work in a well-led way, through high performing teams, can excellent care be sustainable.

It's important to be clear that delivering the following annual operational objectives underpins our ability to deliver on our priorities, and conversely, focusing on the three priorities outlined earlier will directly support the dlivery of these annual objectives.

1.1 Overview of the Trust

University Hospitals Dorset NHS Foundation Trust (UHD) was formed in October 2020 with the merger of Poole Hospital NHS FT and Royal Bournemouth and Christchurch Hospitals NHS FT bringing together teams to service Dorset and beyond.

The Trust spends approximately c£680m and employs c 10000 staff across 3 hospitals – Poole Hospital (PH), Royal Bournemouth Hospital (RBH) and Christchurch Hospital (XCH).



The Trust's services include the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services, delivering the following annual activity:

- 153,000 Type 1 ED attendances
  (Type 3 are transferring to DHUFT on 1st April 2022)
- 73,000 Non-elective admissions
- 73,000 Day case treatment
- 536,000 Outpatient attendances
- 36,000 Planned admissions
- Over 4000 births

These services are provided primarily to a catchment population of approximately 600,000 in the Bournemouth, Poole, Christchurch and east Dorset and New Forest areas.

Specialist services such as vascular, oncology, neurology, cardiology are provided for a wider population of 1 million and most of our services are delivered with our partners including GP’s, social care, ambulance and other NHS services and many others

UHD is undergoing a major building programme in preparation for service reconfiguration. This will create a planned hospital and an emergency hospital from 2026. During 2022/23 we will see the continuation of significant building works and more importantly the integration and development of teams that are ready for the planned service changes. These changes will deliver significantly better, safer and more sustainable care for the population.

Trust Vision, Mission and Values

Underpinning the Mission and Vision are ***our UHD values*** ***(***https://www.youtube.com/watch?v=g18KK8e-x_U&t=6s***)*** . These underpin everything the Trust does and defines how patients and visitors are treated, and also how staff treat each other. The values are embedded into every part of UHD, such as recruitment, appraisal and development.

The Values were drawn up by our staff, facilitated by our Change Champion volunteers, following widespread listening and testing.

UHD has a set ***five strategic objectives*** which are progressed over multiple years. These are:

1. Continually improve quality of patient care
2. Be a great place to work
3. Use our resources well
4. Be well-led and an effective partner
5. Transform our services to better serve patients

Our strategic objectives are revised each year and specific actions set for the year ahead. For 2022/23 there are 15 specific actions as noted overleaf.

		Exec Lead
Strategic Objective 1: To enhance emergency care and hospital flow, and continually improve the quality so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience		
1.1	Improve the safety and experience of emergency patients and their flow, including moving towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partners and improving our own processes to support safe and timely discharge from hospital. To also improve the responsiveness and quality of Urgent and Emergency Care (UEC) as measured by a reduction in 12 hour waits in ED towards zero, minimisation of ambulance handover delays and same day emergency care outcomes supported by implementation of the UEC 10 Point Action Plan.	CMO/ CNO
1.2	To redesign and transform **outpatient services** with a 'digital first' offer, improving access to care, diagnostics strategy delivery, reducing travel times, and through effective completion of care pathways.	COO
1.3	To deliver wide range of **patient safety quality priorities,** using a quality improvement (QI) approach, across the Trust including: • Quality account priorities including Deteriorating Patient and Safety Checklists. • Priorities for 2022/23 including Acute Kidney Injury/Dialysis Management, Blood glucose management, the deteriorating patient in ED and medical/pharmacy communication. Improving against Stroke and Trauma pathway quality standards	COO
Strategic Objective 2: To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.		**Exec Lead**
2.1	To continue to engage with staff at all levels to ensure we maintain focus and realise the **health, wellbeing and Covid-19 recovery** needs and priorities of all our people, investing in appropriate provision of holistic interventions and resources. To engage with staff so that they feel valued and listened to and to strengthen our compassionate and inclusive culture, acting on staff culture champions recommendations and demonstrating success through the national staff survey.	CPO
2.2	To support teams in coming together to operate as a **single team** across UHD sites, embedding our values and behaviours, policies and processes and to identify talent and raise performance and staff engagement across the Trust as measured by an improvement the staff Integration Survey	CPO
2.3	To deliver the Trust's **people strategy** by developing effective and responsive People services, policies and practices for each stage of the employee cycle. This will include workforce planning, recruitment and retention, training and education, employee relations, temporary workforce and workforce systems.	CPO
2.4	To champion **equality, diversity and inclusion** across UHD through positive action and promote initiatives which continue to improve results against workforce equality standards (e.g. WRES and WDES). Implement the National Patient Strategy requirement to develop a just culture across UHD as part of a ICS workforce plan. Define and agree measures to monitor implementation of inclusive leadership, equal opportunities in career development and endorsement of staff networks.	CPO
Strategic Objective 3: To arrange our people and services to best address the planned care backlog, ensuring that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets.		**Exec Lead**
3.1	To deliver a Covid restoration programme that reduces the **elective backlog,** increases activity to pre-pandemic levels and returns waiting times and waiting patient numbers towards the national standards for elective, cancer, diagnostics and emergency care.	CFO
3.2	Agree and deliver a **sustainable budget,** including delivery of the Trust Cost Improvement Programme. This includes realising the opportunities identified in the Getting it Right First Time (GIRFT) and Model Hospital benchmarking data.	COO
3.3	To update and deliver our **green UHD Strategy** and Plan – including reducing our carbon footprint, improving air quality and make more sustainable use of resources.	CSTO
Strategic Objective 4: To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.		**Exec Lead**
4.1	To improve **partnerships and engagement** with staff, governors, patients, local people and key stakeholders through: • a communication and engagement plan, delivered over the year. • Further develop our BU partnership and tangible benefits • Host the Dorset Innovation Hub on behalf of Dorset partner supporting spread of proven innovations	CEO/ CSTO
4.2	Work with partners to address **health inequalities** and improve population health management, preventing ill health and promoting healthy lifestyles.	CFO

Strategic Objective 5: To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our		**Exec Lead**
5.1	Develop the **reconfiguration plan** to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2022, teams being prepared and understanding their trajectory for new estate and new models of care. To ensure that the Outline Business Cases and Full Business Cases for the New Hospital Programme are submitted in 2022/3	CSTO
5.2	Work with system partners in establishing the **Dorset ICS** and within that develop the Dorset provider collaborative.	CEO
5.3	Implement the UHD **digital transformation strategy**: • Progress digital transformation and play an active part in the key Dorset transformation plans programmes • Progress a Digital Dorset Shared Service • Procure and implement the Strategic Integrated Imaging Service: a digital diagnostics image sharing platform for Dorset. • Create the Strategic Outline Case and Outline Business Case for the Dorset Electronic Patient Record system • Ensure that the IT infrastructure and BAU support services are fit for purpose with minimal down-time and the technical layers are subject to a rolling stock replacement programme. • Achieve a compliant Data Protection and Security Toolkit submission.	CIO

Appendix 2 – Finance Section

7. Finance

The national planning guidance for 2022/23 was written at a time when the NHS was operating within a Level 4 National Incident in response to the emergence of the Omicron variant. Despite this, it was felt important to provide certainty and clarity where possible, including setting out the priorities and financial arrangements for the whole of 2022/23. It is recognised however that these will need to be kept under review.

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The Trust has a strong track record of successfully managing its capital budget and this will remain a focus through the Trust Management Group (supported by the Capital Management Group) and assured by the Finance and Performance Committee and ultimately the Board.

Cash

The trust continues to hold a significant cash balance which has been strategically built up over many years and is fully committed, supporting the medium-term capital programme and specifically the unfunded elements of the Dorset Clinical Services Review acute reconfiguration programme.

However, this will be materially depleted if the Trust cannot mitigate the expected revenue deficit, resulting in a requirement to borrow cash in future years.

2022/23 Financial Priorities

The Trust's absolute priority during 2022/23 is to recover the projected revenue deficit thereby mitigating the strategic implications of depleting its cash reserves.

The Trusts approach will be as set out in section 1 above, with an absolute focus on the following key priorities;

- Emergency Care Flow
- Elective Care Productivity
- Sustainable Workforce

In addition to delivering direct financial improvements, making progress in these areas will release clinical and management capacity to focus on further quality improvement, thereby improving productivity and efficiency and reducing waste.

This recovery plan will be underpinned by strong financial governance and control, both within the Trust and across the ICS.

This approach aligns with the wider ICS recovery plan which focuses on:

- Transforming the Urgent and Emergency Care pathway, with a focus on appropriate and timely discharge;
- Recovering the productivity that has been lost through the pandemic;
- Reducing reliance upon premium cost agency staffing; and
- Seeking to remove specific COVID expenditure as we learn to live with COVID.

In addition, the Trust will work with ICS partners to develop a comprehensive medium term financial strategy following receipt of the 2023/24 and 2024/25 revenue allocations which are expected to be published before 30 September

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.12

Subject:	2022/23 Annual Board Certification (G6 and CoS7)
Prepared by:	Pete Papworth, Chief Finance Officer
Presented by:	Pete Papworth, Chief Finance Officer
Purpose of paper:	The Board is asked to consider and approve the annual certification.
Background:	The Trust is required to make the following self-certifications to NHS Improvement: • Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence; and • Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence.
Key points for members:	The completed self-certification is attached confirming compliance with General Condition 6 and confirming compliance with a supporting statement for Continuity of Services condition 7. Assurance and supporting information for these statements has been considered and approved by the Finance and Performance Committee and Board of Directors in the form of the Month 12 Finance Report and draft annual accounts, and the 2022/23 Operational Budget. Whilst the Trust has set a deficit budget of £32 million, it currently has sufficient cash reserves to cover this during 2022/23 whilst a comprehensive financial recovery plan is developed and embedded across the Dorset ICS.
Options and decisions required:	The Board is asked to consider and approve the attached certifications.
Recommendations:	To approve the attached certifications.
Next steps:	The attached self-certification in respect of General Condition 6 of the NHS Provider Licence will be published on the Trust's website by 31 May 2022.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Objective 4: To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well - Led

Committees/Meetings at which the paper has been submitted:	Date

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

University Hospitals Dorset NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: 2022/23 OK

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Consistent with the rest of the NHS the Trust faces a very challenging year as it seeks to recover services in the wake of the COVID-19 pandemic. Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services and increasing numbers of patients in acute hospitals who no longer meet the criteria to reside.

The Dorset ICS has submitted an operational plan which includes a significant financial deficit. Within this, the Trust has reluctantly approved an operational plan inclusive of a revenue deficit of £32.191 million. This reflects the very significant operational pressues stil present together with the recurrent impact of not being able to achieve recurrent efficiencies during the pandemic.

The risks to the availability of required resources consistent with operating within this context have been highlighted in the Trust's annual plan. These risks have been recorded in the Trust's risk register and are regularly monitored and reviewed together with the associated plans to mitigate these risks.

In approving its annual plan the Board of Directors has taken into account the reserves of the Trust, which would enable it to allocate additional resources as required, and has agreed contracts in place with commissioners for the provision of services including detailed cost improvement plans covering this period.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Philip Green	**Name**	Paula Shobbrook
Capacity	Acting Chair	**Capacity**	Acting Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 25 May 2022

Agenda item: 8.13

Subject:	2022/23 Annual Board Certification (FT4 and Training of Governors)
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance and Paula Shobbrook, Acting Chief Executive
Presented by:	Paula Shobbrook, Acting Chief Executive Philip Green, Acting Chairman
Purpose of paper:	To present to the Board the statements required to be made by the Trust by NHSI and to seek its approval of the draft self-certifications.
Background:	The annual self-certification process is to provide assurance that NHS providers are compliant with the conditions of their NHS provider licence. On an annual basis, the licence requires NHS providers to self-certify as to whether they have complied with governance arrangements (CT4). In addition, foundation trusts must review whether governors have received the necessary training to ensure they are equipped with the skills and knowledge they need to undertake their role.
Key points for members:	The Trust is required to make the following self-certifications: • Corporate Governance Statement (FT4); and • Training of Governors (s151(5) of the Health and Social Care Act).
Options and decisions required:	The Board is asked to consider and approve the attached certifications.
Recommendations:	To approve the attached drafts.
Next steps:	Following approval by the Board, the self-certifications will be signed and retained.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Objective 4: To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well - Led

Committees/Meetings at which the paper has been submitted:	Date

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

University Hospitals Dorset NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2021/22**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Mitigants include the Trust maintaining a working register of the principles and provisions from NHSI's (formerly Monitor's) Code of Governance, identifying compliance or where explanation is required. The register is reviewed annually by the Audit Committee and by the Board of Directors. Any areas requiring explanation are reported in the Trust's Annual Report. The Trust also assesses Compliance with NHSI's well led-framework.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Compliance with NHSI's Code of Governance is reviewed annually and areas requiring explanation highlighted in the Trust's annual report. The Trust is a member of NHS Providers and as such is updated regularly on policy updates and takes account of new guidance.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The terms of reference of its committees are reviewed on an annual basis. A governance map is published to give visibility of the governance arrangements in place. Each Board committee reports to the Board on an annual basis with a summary of the work undertaken by the committee during the year and also reports on compliance by the committee with its terms of reference. In addition, an annual review of its own effectiveness shall be undertaken by the Board.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	In addition to 1 & 2 above, the Trust maintains a working register of its assessment of compliance with conditions of its Monitor (NHS Improvement) Licence. The register is reviewed by the Trust's Audit and also comes before the Board annually. The Trust maintains an Annual Governance Statement with work supported by internal and external audit. The Trust maintains an active Risk Management Reporting system. The board meets on a bi monthly basis in public and monthly in private, with standing or specific reports to monitor performance on an integrated basis for each of quality standards, finance, activity, operational performance, staffing and organisational development.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust ensures capable leadership and clear organisational accountability for quality of care provided are in place at Board level and through the triumverate leadership model at a care group and directorate level. Quality sits at the core of the Trust's business and is reflected in its business and transformational planning. The Quality Committee receives accurate data on the quality of care, from sources including the care group reporting, and this information is taken into account by the Board in measuring performance and decision making. The Trust and staff actively engage in improving quality of care with patients and others. Patient stories are heard at the Board. The main surveys of staff and patients have been heard at committees of the Board and the Board receives an annual patient experience report. The results of the friends & family test are reported via the Integrated Performance Report to the Board. Oversight is provided on these activities, through the quality governance framework and reporting to the Quality Committee, via internal and external audit and reporting to the Audit Committee
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Philip Green **Name** Paula Shobbrook

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A: N/A

Worksheet "Training of governors"

Financial Year to which self-certification relates | **2021/22**

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Philip Green	**Name**	Paula Shobbrook
Capacity	Acting Chairman	**Capacity**	Acting Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A